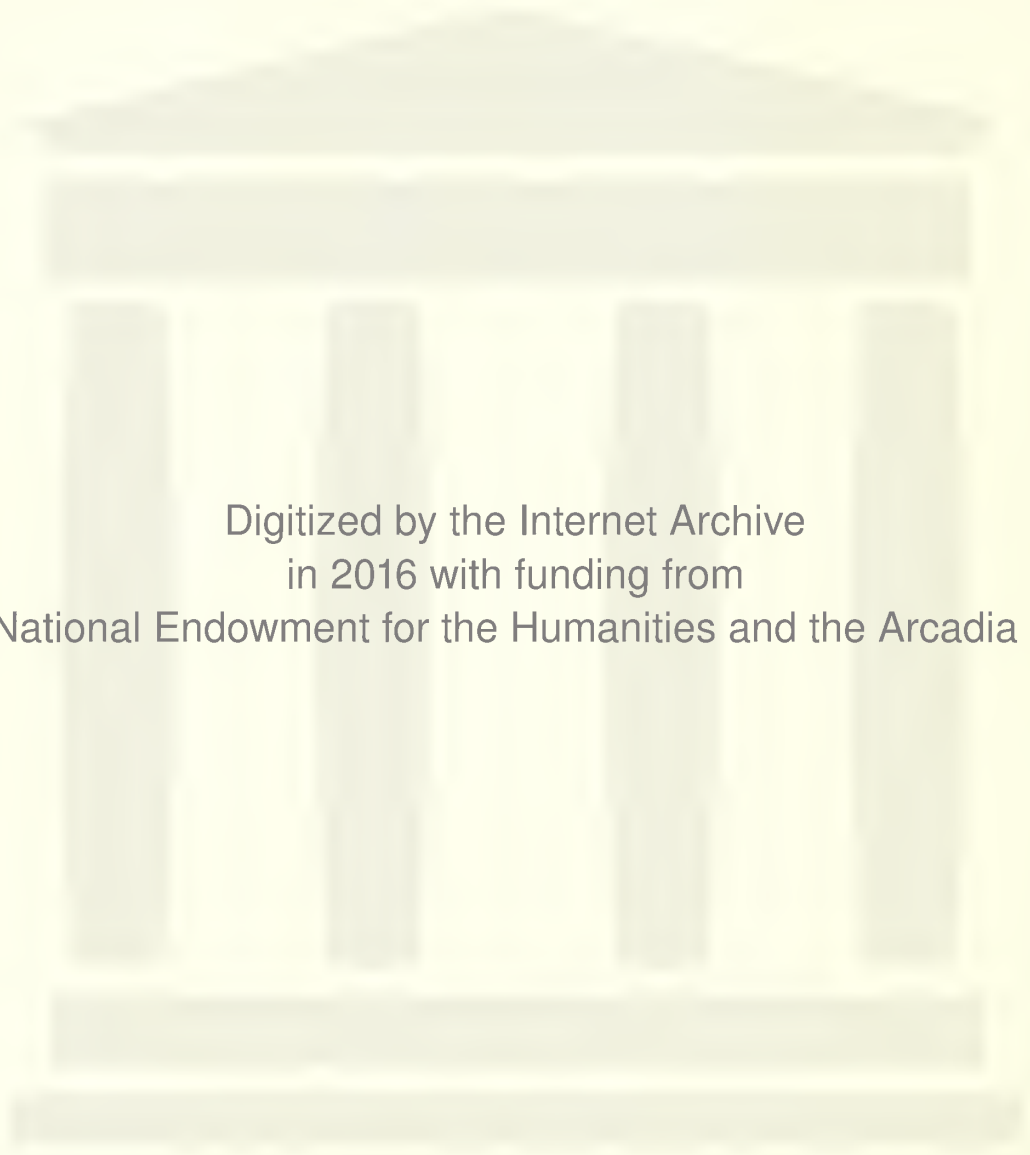


NOT TO CIRCULATE

NOT TO CIRCULATE



Digitized by the Internet Archive
in 2016 with funding from
The National Endowment for the Humanities and the Arcadia Fund

SPECIAL ISSUE: BIOMEDICAL ETHICS

STACKS

NEW JERSEY MEDICINE

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND
BALTIMORE

JAN 20 1989

REC'D.

NOT TO CIRC

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

JANUARY 1989

STACKS

E T H I C S

University of Maryland
Health Science Lib., Serials Dept.
111 South Greene Street
Baltimore, Md. 21201

S

vivo fertilization



QUINLAN

DON'T PLAY DOCTOR WITH YOUR INSURANCE.

Just as you wouldn't want a patient to "play doctor" and self-prescribe too little, too much, or the wrong kind of medicine, we don't want you to play doctor with your insurance.

Protecting your practice, your family, your home and your lifestyle are as important to us as they are to you. As Administrator of these **Medical Society of New Jersey** Endorsed Plans, we're happy to help you with your insurance needs:

**Disability Income, Umbrella Major Medical,
Comprehensive Hospitalization-Major Medical,
Hospital Cash Allowance, and High Limit Accident**

by Nationwide Life Insurance

Term Life Insurance

by Nationwide, Principal and Occidental

Group Keogh Plans

by Prudential and Nationwide

Professional Overhead Expense

by National Casualty Company (a Nationwide Company)



Serving Professionals for Over 60 Years

75 Montgomery Street
Jersey City, N.J. 07302

161 William Street
New York, N.Y. 10038

(201) 333-4340

(212) 732-9435

1 (800) BLANK-AG



NEW JERSEY MEDICINE

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

JANUARY 1989

FEATURES

- 7 Membership Newsletter
- 8 Public Affairs Update
- 11 Professional Liability Commentary

CONTRIBUTIONS

- 17 Introduction: Biomedical Ethics
- 21 Editorial: Ethics or Enigmas?
Howard D. Slobodien, MD
- 23 A Time of Change
Joseph F. Fennelly, MD
- 24 MSNJ and Biomedical Ethics
Palma E. Formica, MD
- 27 The Courts and the PVS Patient
Paul W. Armstrong, JD, and B.D. Colen
- 33 Covenant-Making and Medical Ethics
James S. Todd, MD
- 35 A Quest for Balance
Robert C. Cassidy, PhD
- 38 Committee on Biomedical Ethics
Robert L. Pickens, MD
- 39 Medical Education's Ethical Challenge
Stanley S. Bergen, Jr, MD, and Cheryl J. Tice
- 43 The Challenge of Ethics
T. Patrick Hill and Mary S. Strong
- 45 Nursing Homes and Ethics Committees
Anne R. Somers
- 50 Communication and Altered Perceptions
Kopel Burk, MD
- 53 Ethics in High School
D. Marlene Caruso, RN, MEd, and Heather Marie Smith
- 55 The Democratic Imperative
Patricia Murphy, RN, PhD

DOCTORS' NOTEBOOK

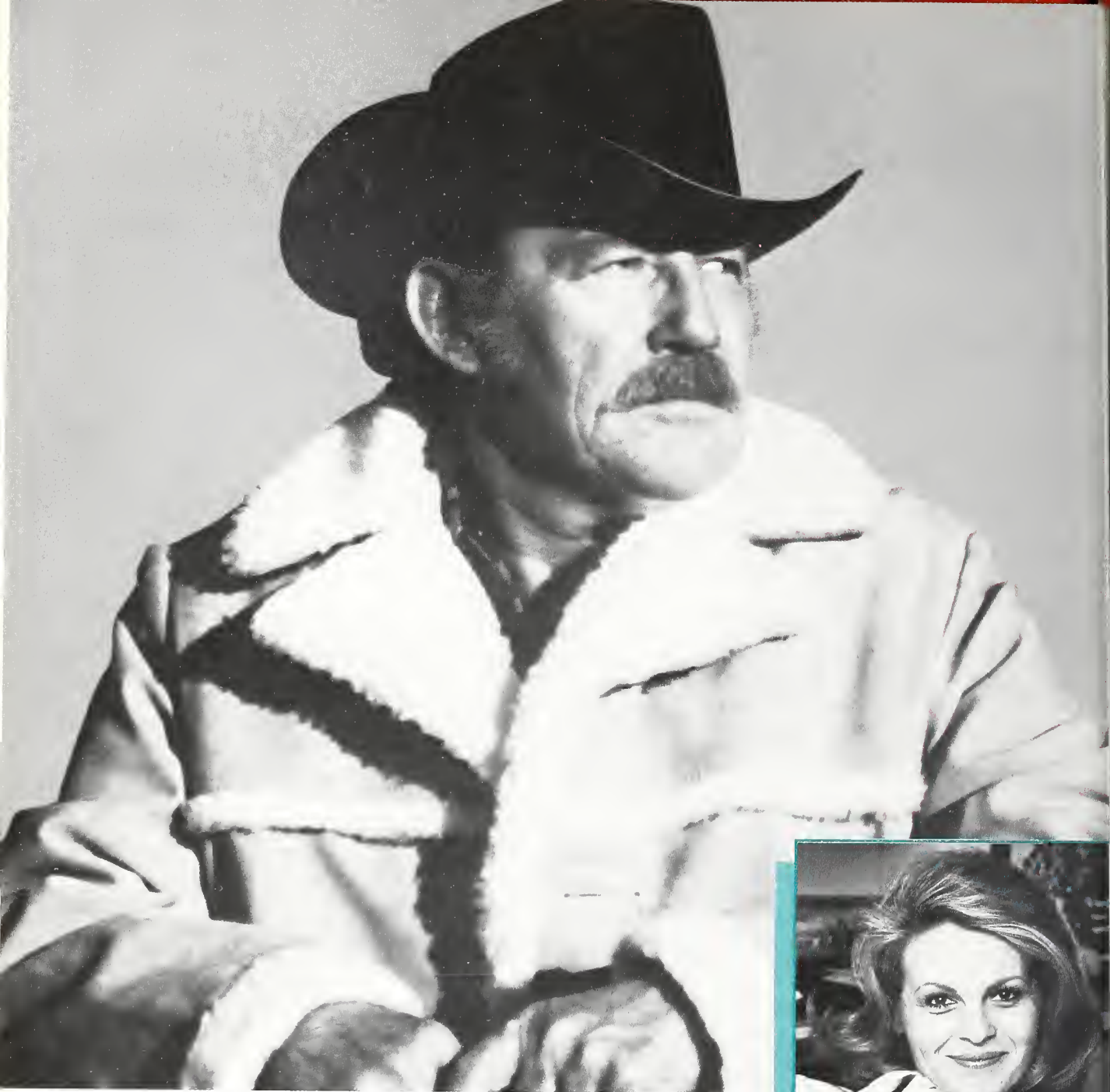
- 59 Trustees' Minutes: November 20, 1988
- 60 UMDNJ Notes
- 61 AMNJ Report
- 62 Physicians Seeking Location in New Jersey

MSNJ DEPARTMENTS

- | | |
|--------------------------|-----------------------|
| 65 CME Calendar | 70 Obituaries |
| 68 Letters to the Editor | 72 Author Information |
| 69 Book Reviews | |

On The Cover: This special issue on biomedical ethics is dedicated to David Eckstein, MD, the first chairman of the MSNJ Committee on Biomedical Ethics. Cover: Will Harmuth.





Dosing Flexibility

 **Android**[®] / 5^{Buccal} / 10^{Oral} / 25^{Oral}
mg mg mg

Methyltestosterone U.S.P. Tablets

 **ANDROID**[®] / F

Fluoxymesterone U.S.P. Tablets, 10 mg.



For Full Prescribing
Information,
Please See PDR

BROWN BROWN PHARMACEUTICAL COMPANY, INC. 3300 Hyland Avenue, Costa Mesa, CA 92626

NEW JERSEY MEDICINE

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

FEBRUARY 1989

FEATURES

- 83 Membership Newsletter
- 87 Public Affairs Update
- 89 Professional Liability Commentary
- 93 President's Page
- 95 Editorial
- 96 Special Editorial

CONTRIBUTIONS

- 99 Teaching Psychiatry to Primary Care Residents in a Community Hospital
Roger B. Granet, M.D., Morristown
- 105 Quality Assessment Mechanism in Medicare Contract with The PRO of New Jersey, Inc.
David I. Kingsley, M.D., East Brunswick
- 109 Diagnostic Dilemma of Aortic Aneurysms: Internist's Perspective
Robert C. Mayer, M.D., and Elliot Frank, M.D., Neptune
- 115 Upright and Supine Flow-Volume Curves in Patients with OSA
Jeffrey Nahmias, M.D., and Monroe S. Karetzky, M.D., Newark
- 123 A Physician's Duty To Disclose that his Patient Has AIDS
Gary D. Nissenbaum, M.D., Newark
- 127 Commentary: Physician Peer Review in New Jersey
William A. Dwyer, Jr., M.D., Fair Lawn

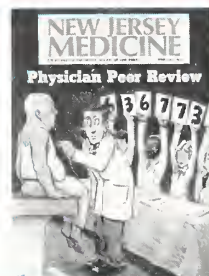
DOCTORS' NOTEBOOK

- 135 Trustees' Minutes
- 137 UMDNJ Notes
- 138 Auxiliary Report
- 139 Physicians Seeking Location in New Jersey

MSNJ DEPARTMENTS

- 145 CME Calendar
- 150 Book Reviews
- 151 Obituaries

On The Cover: Our commentator details the current status of physician-controlled review of medical care, beginning on page 127.
Cover: Frank Cecala



Where do physicians turn for financial services?

AMA Advisers, Inc. . . . Investment experts for physicians and their families nationwide

More and more physicians are turning to AMA Advisers, Inc. for investment expertise. For good reasons.

Specializing in serving AMA members and their families, AMA Advisers, Inc. offers you a complete menu of investment opportunities tailored to meet your individual needs. From conservative money market mutual funds to aggressive growth mutual funds. From annuities to certificates of deposit and an impressive array of retirement plans.

AMA Money Fund . . . Offering you both safety and liquidity

- High Current Money Market Rates—The Fund pays dividends daily . . . so your investment grows daily!
- Liquidity—free checkwriting and telephone redemption privileges.
- Safety—The AMA Money Fund invests in only the highest quality money marketing obligations and seeks to maintain a constant \$1 per share net asset value.
- No sales charge—100% of your investment is put to work immediately. The fund uses a 12b-1 plan of distribution.

Find out how AMA Advisers, Inc. can serve all your investment and retirement plan needs.

Send the coupon today or . . . Call toll-free

1-800-262-3863!

**and get the 1989 Arthur Young
Pocket Tax Guide Free!**

**1988-1989
Federal Tax
Highlights**

**FREE
1989
Pocket
Tax Guide!**

☐ **YES! I want to earn high current money market rates while enjoying the safety and liquidity of the AMA Money Fund. Please send me more complete information, including charges and expenses, and a free prospectus. I will read the prospectus carefully before investing.**

☐ **I also want to save money on next year's taxes. Send me the 1989 edition of the compact, easy-to-use Arthur Young's Pocket Tax Highlights—FREE!**

Name: _____

Address: _____

City: _____ State _____ Zip _____

Phone: (____) _____

Best time to call: _____

Mail this coupon to:
The AMA Group
P.O. Box 1923
West Chester,
PA 19380-1923

AMA ADVISERS, INC.
The Financial Services and Investment
Counseling Organization Owned by the
American Medical Association

Established in 1966



NJMF02

NEW JERSEY MEDICINE

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

MARCH 1989

FEATURES

- 162 Membership Newsletter
- 163 Public Affairs Update
- 169 Professional Liability Commentary
- 173 President's Page
- 177 Editorial

CONTRIBUTIONS

- 181 For-Profit Smoking-Cessation Programs and Their Clients
Ronald L. Caplan, Ph.D., Michael Greenberg, Ph.D., Lisa Bellet, M.P.H., New Brunswick
- 185 The Importance of Documentation in Peer Review
David I. Kingsley, M.D., East Brunswick
- 189 The Uncompensated Care Trust Fund and the Medicare Waiver
Molly Joel Coye, M.D., M.P.H., Trenton
- 193 Dr. Muriel M. Gardiner: Psychiatrist and Philanthropist
Fred B. Rogers, M.D., Trenton
- 197 Limited Resections for Lung Cancer
Lewis Wetstein, M.D., and Amy Brenner, R.N., Freehold
- 203 Special Article: Your Prescription—an Instrument of Your License
Frank J. Malta, M.D., Toms River
- 207 Special Article: Of Feelings and Manners
Edith T. Shapiro, M.D., Englewood
- 211 Case Report: Success of Ceftrizoxime in *E. Coli* Ventriculitis
Pierre N. Coant, M.D., Sidney J. Sussman, M.D., Elizabeth Fong-deLeon, M.D., Camden
- 213 Review Article: Methotrexate in the Rheumatic Diseases
Sheldon D. Solomon, M.D., Cherry Hill

DOCTORS' NOTEBOOK

- 218 Trustees' Minutes: January 15, 1989
- 218 MSNJ Auxiliary
- 219 AMNJ Report
- 220 Physicians Seeking Location in New Jersey

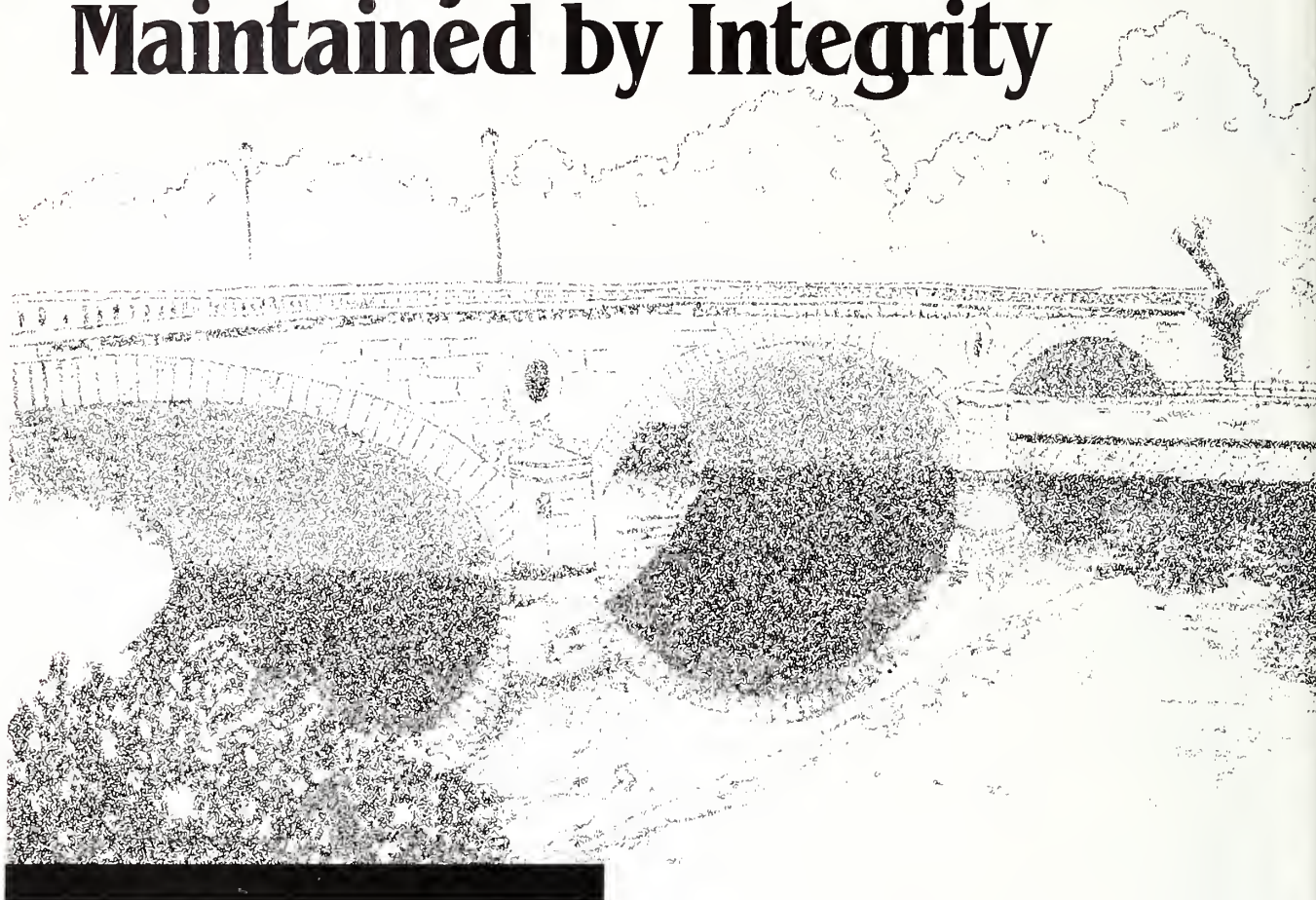
MSNJ DEPARTMENTS

- 223 CME Calendar
- 231 Letter to the Editor
- 232 Book Reviews
- 233 Obituaries

On The Cover: Our lead story discusses for-profit smoking-cessation programs serving New Jersey. Cover illustration: R.L. Rebach.



Built by Dedication, Maintained by Integrity



THE REHABILITATION INSTITUTE OF MORRISTOWN MEMORIAL HOSPITAL PROVIDES:

- Patient return to *maximum possible functionality* at earliest reasonable time,
- Full *cooperation* and feedback with members of the referring medical team and patient families,
- *Cost effectiveness* combined with the highest rehabilitation standards,
- *Skilled and empathetic* treatment from all members of the rehabilitation team,
- Ultramodern facilities and equipment backed up with the *resources of a large 687-bed teaching hospital* with widespread affiliations.

We welcome your inquiries and would like to send you detailed information. Please contact:

Joyce P. Hildenbrand, MSW, CSW,
Director, Patient Referral Services
The Rehabilitation Institute
Morristown Memorial Hospital
P.O. Box 1978
Morristown, N.J. 07962-1978
Phone: 201/285-4418

Equal Opportunity Employer

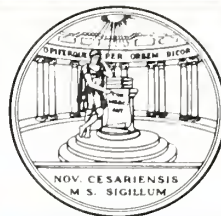


MORRISTOWN MEMORIAL HOSPITAL

Founder member Atlantic Health Systems, Inc.

NEW JERSEY MEDICINE

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY



CONTRIBUTIONS

- 269** The Evolution of a Journal
Geraldine Hutner, MA
- 277** D&C Results Improved by Hysteroscopy
Herbert A. Goldfarb, MD
- 281** Pancreatitis of Pancreas Divisum
M. Nuri Kalkay, MD; Arnold Derman, MD
- 286** PRO Review of Intervening Care
David I. Kingsley, MD
- 289** Chlamydia Trachomatis
Joseph M. Lombardo, MD, PhD; Cynthia A. Smith, MT;
Lily L. Siddiqui, MT; Stanley J. Robboy, MD
- 295** Unusual Presentation: Testicular Seminoma
Gregory Szypula, MD; Purnendu Sen, MD; Kong L. Tan, MD;
John R. Middleton, MD; Margaret Kuza, MD
- 299** Carcinoid Tumor of the Testicle
Joel W. Rosenberg, MD; Monica Yang, MD

DEPARTMENTS

- 249** MSNJ Newsletter
- 255** Capitol Commentary
Clark Martin
- 257** Professional Liability
James E. George, MD, JD
A. Ronald Rouse
- 261** President's Page
Palma E. Formica, MD
- 265** Book Reviews
- 301** Nominating Report
- 315** In Memoriam

EVOLUTION OF A JOURNAL

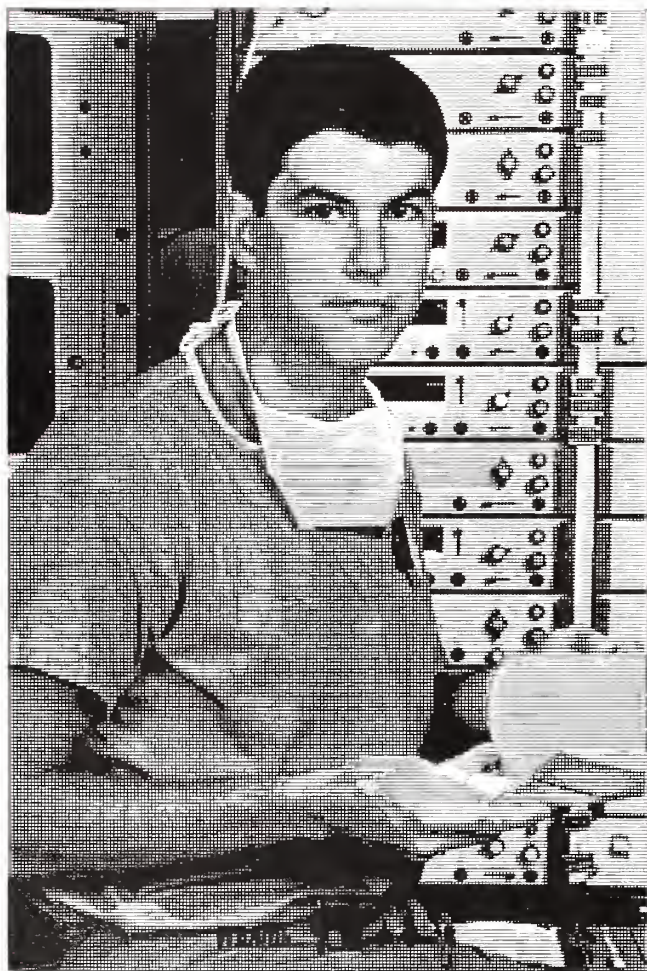


This issue marks a major change for our journal, in style and content. The cover highlights the evolution of NEW JERSEY MEDICINE. The story begins on page 269.

NOTEBOOK

- 303** Continuing Education
- 309** UMDNJ Notes
- 310** MSNJ Auxiliary
- 310** Legislation
- 312** New Members
- 313** Placement File

PHYSICIANS, THERE ARE TWO KINDS OF FLEXIBILITY IN THE ARMY RESERVE WE THINK YOU'LL LIKE.



One, time. We know how tough it is for a busy physician to make weekend time commitments. So we can offer the kind of flexible time scheduling that allows a physician to share sixteen hours a month with his or her country. We can arrange a schedule to suit your requirements.

Two, the opportunity to explore other phases of medicine, to add a different kind of knowledge — the challenge of military health care. It's a flexibility that could prove to be both stimulating and rewarding, with the opportunity to participate in a variety of programs that can put you in contact with medical leaders from all over the country.

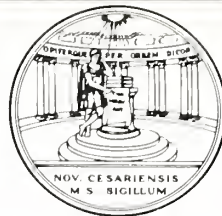
See how flexible we can be; call our Army Medical Personnel Counselor:

Major Claudia Gibson
609-667-8190
Collect

BE ALL YOU CAN BE.
ARMY RESERVE

NEW JERSEY MEDICINE

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY



CONTRIBUTIONS

- 345** Skin Cancer in New Jersey: Skin Sense
Christopher M. Papa, MD
- 348** Sun Protection and Skin Cancer
Richard S. Berger, MD
- 353** New Jersey Skin Cancer Screening Program
Christopher M. Papa, MD
- 361** Tretinoin Therapy for Precancerous Skin
Christopher M. Papa, MD
- 369** Mohs Micrographic Surgery
Manuel R. Morman, PhD, MD
- 377** Chronic Arsenicism
Lynn K. Bickley, MD
Christopher M. Papa, MD
- 383** Xeroderma Pigmentosum
W. Clark Lambert, MD, PhD
- 389** Dysplastic Nevi and Melanoma
Sandy S. Milgraum, MD
Christopher M. Papa, MD
- 395** Cutaneous T Cell Lymphoma
Sophie M. Worobec-Victor, MD
- 401** Melanoma-Pigmented Lesion Center
Dennis F. Devereux, MD

DEPARTMENTS

- 335** MSNJ Newsletter
- 336** Capitol Commentary
Clark Martin
- 337** Professional Liability
James E. George, MD, JD
A. Ronald Rouse
- 339** President's Page
Palma E. Formica, MD
- 340** Editor's Desk
Howard D. Slobodien, MD
- 343** Book Reviews

NEW JERSEY
MEDICINE



Skin cancer is the most common cancer. This special issue is devoted to the problems of and solutions to this deadly disease. The coverage begins on page 345.
Cover: William Harmuth.

NOTEBOOK

- 405** Continuing Education
- 407** Trustees' Reports
- 410** ICD-9 Order Form
- 410** UMDNJ Notes
- 411** Placement File
- 413** In Memoriam

GO...GO... GO...PHONE

"Premium Cellular"

1174 CHESTNUT STREET

ELIZABETH, NEW JERSEY 07201

CELLULAR PHONES—CAR PHONES, TRANSPORTABLES, PORTABLES

Thinking of a New or Second Car Phone?

Is a Lightweight Portable Phone Perfect For Your Days On-Call?

Go . . . Go . . . Phone specializes in Physician Cellular Service.

Bonded Installers travel to your home, hospital or office.

NEC 3700 dual nam phones now available!

Nynex and Metro numbers activated within 1 day.

SPECIAL OFFER—Thru 6/30/89—Big Savings

Your first 100 minutes of usage will be rebated by Go . . . Go . . . Phone.

EXECUTIVE FAX MACHINES—PERFECT FOR YOUR HOME OR OFFICE

Every MD can utilize a Fax to send and receive patient reports from hospitals, imaging centers and referrers.

Go . . . Go . . . Phone is a proud distributor of  **Cobra®**
 **Cobra®** PP110—\$899

Other models available

Call today for a demonstration and/or price quote.

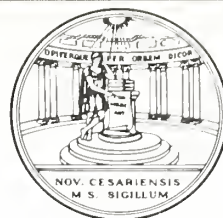
Contact Mr. Fred Glick at 201-761-7605.

Cellular phone service provided through



NEW JERSEY MEDICINE

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY



CONTRIBUTIONS

- 451** Inaugural Address
Paul J. Hirsch, MD
- 455** Presidential Address
Palma E. Formica, MD
- 457** Steroid Use
in Asthmatics
Marc Adelman, MD
Benjamin H. Safirstein, MD
- 465** Pyoderma
Gangrenosum
Jeffery W. Seitzinger, MD
- 469** Ciguatera Fish
Poisoning
M. Arif Hashmi, MD
Jeffrey J. Sorokin, MD
Stephen M. Levine, MD
- 473** Aseptic Synovitis
J.G. Barone, MD
C.J. Wang, MD
J.E. Barone, MD
- 475** Varicella Pneumonia
in the Adult
John A. Conti, MD
Monroe S. Karetzky, MD

DEPARTMENTS

- 427** Capitol Commentary
Clark Martin
- 431** Professional Liability
James E. George, MD, JD
A. Ronald Rouse
- 435** Editor's Desk
Howard D. Slobodien, MD
- 437** Book Reviews
- 440** Letters & Viewpoints
- 445** Golden Merit Awards
- 486** In Memoriam

NEW JERSEY MEDICINE



The Cover: Dr. Paul Hirsch is the 197th president of the Medical Society of New Jersey. Photographer: Roupen Agopian, from Bacharach, New York.

NOTEBOOK

- 479** Trustees' Report
- 481** UMDNJ Notes
- 482** New Members
- 483** Physician Specialist
- 483** What Time Is It?
- 483** Placement File
- 485** Continuing Education
- 487** Editorial Criteria

We Keep Pace, So You Can, Too!

Keeping pace with the latest advances and improvements is important in many industries. But in the orthotics and prosthetics field, it's critical.

Because when we keep pace, it helps our patients keep pace.

In addition to the latest products and devices, the professionals at Harry J. Lawall & Son also keep pace with the newest fitting techniques and the most current industry knowledge.

Because the better we keep pace, the better our patients can, too.

Harry J. Lawall & Son, Inc.

Professional Orthotic and Prosthetic Services

3100 Princeton Pike, Bldg. 1 • Lawrenceville, NJ 08648

(609) 691-7764

NOW IS THE TIME TO MARKET YOUR PRACTICE.

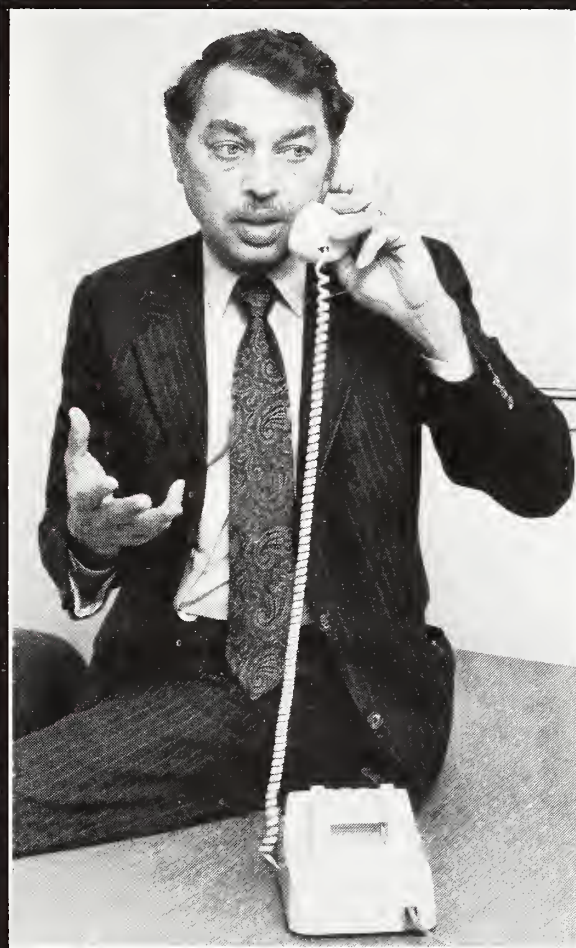
We work with
both surgical and
medical specialties.

Call now
for FREE information:
Rebecca Anwar, Ph.D.
(215) 649-8770



Hoover Anwar Associates
Medical Marketing Services

First Pennsylvania Bank Building
Seven East Lancaster Avenue
Ardmore, PA 19003



"Your patient is doing fine"

When your patient comes to the Eastern Heart Institute for diagnosis or treatment, expect a personal phone call from one of our physicians.

Ongoing communication between the referring doctor and the EHI makes the Institute one of the most physician friendly cardiac care programs in New Jersey. For an appointment to tour our state-of-the-art facility or to receive a brochure, please call.



**The
Eastern
Heart
Institute**

THE GENERAL HOSPITAL CENTER
at Passaic

350 Boulevard • Passaic • NJ 07055

1-800-432-7834

NEW JERSEY MEDICINE

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY



CONTRIBUTIONS

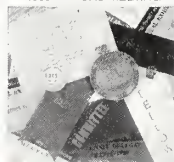
- 531** Polyendocrine Failure with Hypogonadism
Jesus R. Alfonso, MD
Michael H. Goldman, MD
Jeffrey Kocher, MD
- 533** Microbiological Contamination
Molly Joel Coye, MD, MPH
Marcia Goldoft, MD, MPH
- 541** Chronic Confusional State
William J. Mullally, MD
Michael Ronthal, McBCCh
Kenneth Huff, MD
Norman Geschwind, MD
- 547** The Physician and Patient
Richard Fadil, MD
- 548** PTCA in Anomalous Coronary Artery
Richard D. Goulah, MD
Jonathan E. Goldstein, MD
Jacob I. Haft, MD
- 551** Financing Medical Education
J.A. Lieberman, III, MD
Cynthia Baranski, RN
- 554** Ammonia Encephalopathy
Steven Peltz, MD
Sophia Schwartzman, MD
Barry Cohen, MD
- 557** Idiopathic Unilateral Hyperlucent Lung
Hemant Patel, MD
Monroe S. Karetzky, MD
- 572** 1989 MSNJ Annual Meeting Transactions

DEPARTMENTS

- 503** MSNJ Newsletter
- 507** Legislative Update
June O'Hare
- 515** Capitol Commentary
Clark Martin
- 517** Professional Liability
James E. George, MD, JD
A. Ronald Rouse
- 521** President's Page
Paul J. Hirsch, MD
- 525** Editor's Desk
Howard D. Slobodien, MD

NEW JERSEY MEDICINE

1989 ANNUAL MEETING



Cover: Transactions of the MSNJ Annual Meeting begin on page 572.
Photograph: Spud Grammar

NOTEBOOK

- 527** Book Reviews
- 561** Trustees' Reports
- 564** UMDNJ Notes
- 565** MSNJ Auxiliary
- 565** Placement File
- 567** Continuing Education
- 569** In Memoriam

AXID®

nizatidine

Enhances compliance and convenience

Patients appreciate Axid, 300 mg, in the Convenience Pak

In a Convenience Pak survey (N = 100)¹

- 100% said the directions on the Convenience Pak were clear and easy to understand
- 93% reported not missing any doses

Pharmacists save time – at no extra cost

- The Convenience Pak saves dispensing time and minimizes handling

The Convenience Pak promotes patient counseling

- Pharmacists dispensing the Axid Convenience Pak can encourage compliance and continued customer satisfaction



Convenience Pak is available at no extra cost



Eli Lilly and Company
Indianapolis, Indiana
46285

AXID®

nizatidine capsules

Brief Summary

Consult the package literature for complete information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks. Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg b.i.d. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H₂-receptor antagonists.

Precautions: General – 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.
2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests: False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions: No interactions have been observed between Axid and theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility: A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules in the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose as indicated by a significant weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice, and no evidence of a carcinogenic effect in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy – Teratogenic Effects – Pregnancy Category C: Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.1%), and constipation (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic: Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular: In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS: Rare cases of reversible mental confusion have been reported.

Endocrine: Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecostasia occurred.

Hematologic: Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H₂-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumentary: Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity: As with other H₂-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H₂-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other: Hyponatremia associated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdose: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

Signs and Symptoms: There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg, respectively.

Treatment: To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the Physicians' Desk Reference (PDR). In managing overdose, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdose occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

PV 2096 AMP

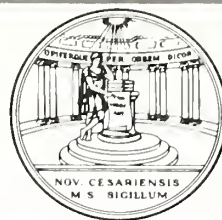
[013089]

Additional information available to the profession on request.

¹ Data on file, Lilly Research Laboratories.

NEW JERSEY MEDICINE

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY



CONTRIBUTIONS

- 611** Aortic Balloon
Valvuloplasty
Se Do Cha, MD
Anil G. Kothari, MD
Ronald I. Weiner, DO
Constantine Kashnikow, MD
Michael A. Wappel, MD
Cecelia Roman, DO
Vladir Maranhao, MD

- 615** The Gift of Life
Ronnee H. Jacobson

- 617** Current Concepts in
Narcolepsy
Jeffrey Nahmias, MD
Monroe S. Karetzky, MD

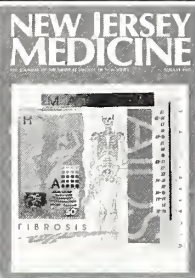
- 623** Impaired Bone Marrow
in AIDS
Kumudini U. Mehta, MD
Pedro Gascon, MD, PhD
Nizar Tannir, MD
Joseph Lombardo, MD, PhD
Stanley J. Robboy, MD

- 629** Chondrosarcoma and
Malignant Lymphoma
Linda Murakata, MD
Anis F. Rangwala, MD

- 633** Bilateral Adrenal
Hemorrhage
Anna M. Champlin, MD
Joel A. Budin, MD

DEPARTMENTS

- 587** Capitol Commentary
Clark Martin
- 591** Professional Liability
James E. George, MD, JD
A. Ronald Rouse
- 595** President's Page
Paul J. Hirsch, MD
- 599** Editor's Desk
Howard D. Slobodien, MD
- 603** Book Reviews
- 605** Letters & Viewpoints



The Cover: Bone marrow biopsies from 50 patients with AIDS were studied. The results of this study are discussed on page 623. Cover: © Will Harmuth.

NOTEBOOK

- 635** Trustees' Report
- 636** UMDNJ Notes
- 637** Legislation
- 639** Placement File
- 641** Continuing Education
- 647** In Memoriam
- 650** Editorial Criteria

MEDICAL OFFICE MANAGEMENT SOFTWARE

\$750.00

Instant medical forms/monthly statements including IDC codes
Comprehensive. IBM XT, AT, clones
Purchase software only (FREE DEMO DISK) or Complete system (hardware/software) for less than \$2000.00

Leonard Waldman MD FACS 201-355-3700

700 North Broad Street
Elizabeth, NJ 07208

**Entrepreneurs
& professionals
often need
to take a fresh
look at their
own business...**



Rita Ben-Ami
Business Management Services

We offer new
perspectives and alternatives
for growth and management

Ben-Ami Inc.
63 Ash Street, Englewood Cliffs, NJ 07632
201/569-0616

The Breathing Center



*Making
Your Job
A Little Easier*

**Diagnosing and Rehabilitation
Are Our Business... Let Us Assist You**

The Breathing Center, a group of private medical centers specializing in diagnosing and rehabilitation of pulmonary disorders, has worked with hundreds of New Jersey physicians and helped thousands of their patients. We also specialize in sleep apnea evaluation services, assisting area physicians and health professionals

Our assistance includes full diagnostic evaluation and rehabilitation of your patients. We return to your good care more manageable, knowledgeable and healthier patients with improved lifestyles and a decreased need for hospitalization. Pulmonary rehabilitation compliments your care

Call our patient coordinator today for more information. In Northern New Jersey call our Morristown Center at 539-5330 or in Central and Southern New Jersey call our Edison Center at 417-9339.

T H E V I T A L S I G N O F PHYSICIANS' INSURANCE



More NJ physicians choose MSNJ Group Health Care Plans than all other policies combined — because they know how vital quality health care insurance is.

- Blue Cross/Blue Shield and Major Medical Insurance
- Dental Insurance
- Long-Term Care Insurance

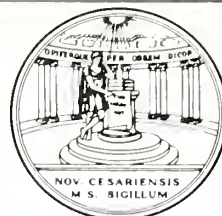
F O R M O R E I N F O R M A T I O N

CALL The Insurance Solutions People at 609 924-8700

DONALD F. SMITH & ASSOCIATES

NEW JERSEY MEDICINE

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY



CONTRIBUTIONS

- | | |
|--|---|
| <p>682 What's So Special About CME?
Alan J. Lippman, MD
James H. Thorpe, MD</p> <p>686 Continuing Medical Education
James H. Thorpe, MD</p> <p>688 CME and MSNJ
Bernardo Toro-Echague, MD
Martin E. Johnson</p> <p>693 AMNJ
Alfred A. Alessi, MD
Ronnie Davidson, EdD
Charles J. Heitzmann</p> <p>699 The Role of AMNJ
Charles J. Heitzmann</p> <p>701 Hospital Medical Education
Stephen F. Wang, MD
Ronnie Davidson, EdD</p> | <p>703 NJHA and Continuing Education
Louis Scibetta</p> <p>707 The Academic Health Center
Robert R. Moutrie, PhD
William S. Vaun, MD</p> <p>709 Down-to-Earth Medical Education
Richard K. Goodstein, MD</p> <p>713 The Computer Connection
Steven Marcus, MD</p> <p>715 The Pharmaceutical Industry
Robert Heller</p> <p>717 A Time of Change for CME
Richard E. Dixon, MD</p> |
|--|---|

DEPARTMENTS

- 662** MSNJ Newsletter
- 670** Professional Liability
James E. George, MD, JD
A. Ronald Rouse
- 673** President's Page
Paul J. Hirsch, MD
- 677** Editor's Desk
Howard D. Slobodien, MD
- 679** Book Reviews
- 733** In Memoriam

NEW JERSEY MEDICINE



The Cover: This special issue is dedicated to the why and how of continuing medical education in New Jersey.
Photograph: Karen Fucito.

NOTEBOOK

- 721** Trustees' Report
- 723** UMDNJ Notes
- 724** MSNJ Auxiliary
- 725** New Members
- 725** Placement File
- 727** Continuing Education

"The ease of operation of the HM-4 for the patient, staff and physician is far superior to the HM-3".

Dr. Joseph S. Ritter
Summit, NJ



"The location; the ease of the valet parking; the decor; and the way the patients are cared for—the response has been favorable".

Dr. Franklin Morrow
Roselle, Rahway, NJ



"The Stone Center is a first class operation starting from the receptionist at the front desk, through the nursing staff and technicians to Arlyn (R. Arlyn Rayfield, Executive Director)".

Dr. Patrick N. Ciccone
Belleville, Livingston and
West Patterson, NJ



WAVE REVIEWS

Why the accolades?

Over the past year we've successfully treated more than 1500 patients. And with over 100 affiliated urologists on staff, we asked a few to share their thoughts on our Center.

Perhaps their comments come from knowing that their patients were treated in a sophisticated atmosphere by the state's top lithotripsy professionals.

Or perhaps, it's the extra efforts we make to ensure that our physicians and patients are happy, such as...

- providing a patient representative who will schedule your cases for you and make sure all of your special requirements are taken care of.
- our Physician Referral Service, which provides prospective patients with the names of affiliated physicians located in their geographic locations.
- our convenient valet parking.
- our new expanded hours (6:30 AM - 7:00 PM) and Saturday availability.
- our physician newsletter, created to keep you abreast of the latest technology, events and occasions at The Stone Center.

If you are not familiar with The Stone Center, contact Arlyn Rayfield, Executive Director, today, and schedule an appointment for machine demonstrations or to receive additional information on ESWL® treatment.

Your patients will thank you for it.



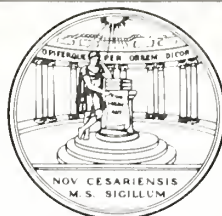
150 Bergen Street
Newark, New Jersey 07103-2425
(201) 456-4765

...for the new wave in kidney stone treatment.

The Stone Center is northern New Jersey's only certified lithotripsy facility -- therefore the procedure is supported by most medical insurers.

NEW JERSEY MEDICINE

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY



CONTRIBUTIONS

769 The Race for Governor
Jim Courter
James J. Florio

773 Alcoholic
Cardiomyopathy
Robert M. Kosinski, MD

779 Gastrostomy
Tube-Feeding
Michael A. Nevins, MD

785 Left Atrial Myxoma
Ramzi A. Tabbalat, MD
Jacob I. Haft, MD

791 Treating Anxiety in
Primary Care
Kenneth J. Weiss, MD

795 State Programs for the
Elderly
Anthony M. Villane, Jr, DDS

797 Resection of Proximal
Bile Duct Cancer
Bernard Gardner, MD

800 Early Stage Pure
Seminoma Testis
Andrew Zablow, MD
Paul Erba, MD
Louis J. Sanfilippo, MD

DEPARTMENTS

751 MSNJ Newsletter

757 Professional Liability
James E. George, MD, JD
A. Ronald Rouse

761 President's Page
Paul J. Hirsch, MD

765 Editor's Desk
Howard D. Slobodien, MD

766 Book Reviews

815 In Memoriam

NEW JERSEY
MEDICINE



The Cover: Anxiety disorders are highly treatable problems seen in primary care. A study of the treatment programs begins on page 791.
Cover: Will Harmuth.

NOTEBOOK

804 UMDNJ Notes

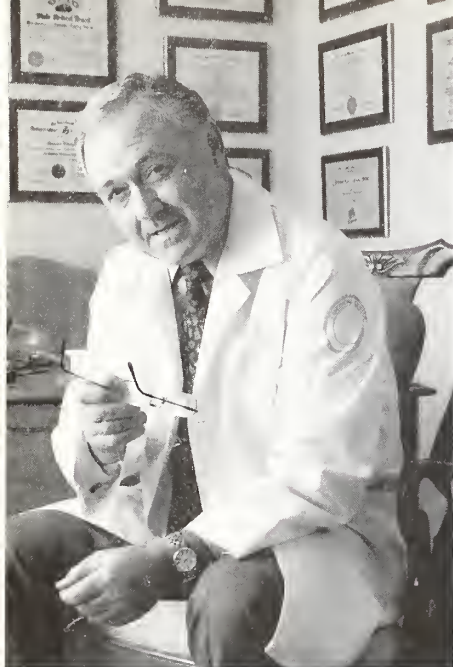
804 AMNJ Report

805 Placement File

807 Continuing Education

816 Editorial Criteria

817 1990 NJM Rate Card



**"A big insurance company
that's really listening to me?"**

**I don't
believe it."**

Believe it! Medallion. From Blue Cross and Blue Shield

We listened to you because we all share a common concern—the welfare of your patients.

After listening to your needs, we've developed the best insurance for a healthy practice...and your patients.

The result is Medallion.

Comprehensive fee-for-service.

The fee-for-service insurance program you want, with comprehensive medical coverage your patients need. Including office visits, well child care and unlimited laboratory and X-ray services.

Fast & simple.

Blue Cross and Blue Shield guarantees Reasonable and Customary reimbursement. And, once we receive the usual claim form from you, you'll be pleased with our quick, direct payment.

Patient referral.

Our Blue Cross and Blue Shield referrals can help build your practice. Over 40,000 prospective patients will call us this year, asking about Blue Cross and Blue Shield participating physicians. We're eager to guide them to you.

Superior programs like Medallion are proof that Blue Cross and Blue Shield is responding to the changing needs of New Jersey's medical professionals, and offering advantages to the more than 10,000 physicians throughout the state who participate with Blue Cross and Blue Shield.

If you're not yet a participating physician with Blue Cross and Blue Shield, why not find out how we can help your practice. Call 1-800-842-BLUE for more information. Of course, there's no obligation.



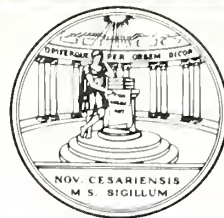
The best insurance for a healthy practice



® Registered Marks Blue Cross and Blue Shield Association ® Registered Mark Blue Cross and Blue Shield of New Jersey, Inc.

NEW JERSEY MEDICINE

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

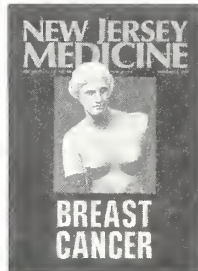


CONTRIBUTIONS

- 859** Cytological Diagnosis of Breast Cancer
Anis F. Rangwala, MD
Magaly Perez-Blanco, MD
Jane Reilly, CT
- 867** Trends in Cesarean Section Rates
George J. Halpin, MD, MPH
Elaine Rose, PhD
Elizabeth Shapiro, MPH
- 875** Prevention of Handgun Deaths
Robert Eilers, MD
- 879** Radiotherapy T, Glottic Carcinoma
Andrew I. Zablow, MD
Paul S. Erba, MD
Louis J. Sanfillippo, MD
- 883** Endoscopic Nasal Surgery
Tong H. Chun, MD
Todd A. Morrow, MD
- 887** Acromegaly
Michael H. Goldman, MD
Karl Klinges, MD

DEPARTMENTS

- 833** Professional Liability
James E. George, MD, JD
A. Ronald Rouse
- 839** MSNJ Newsletter
- 845** President's Page
Paul J. Hirsch, MD
- 847** Editor's Desk
Howard D. Slobodien, MD
- 851** Book Reviews
- 855** Letters & Viewpoints
- 891** Committees & Councils
- 916** In Memoriam



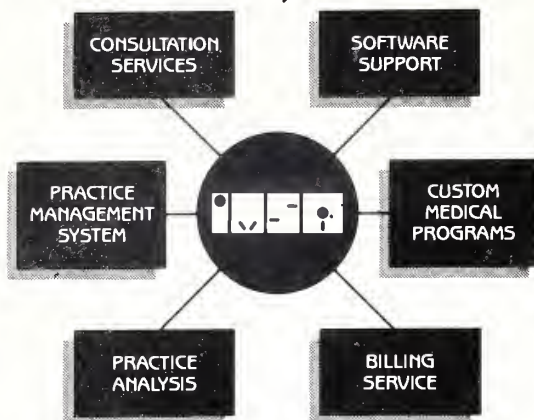
The Cover: Our cover story details the cytological diagnosis of breast lesions, a useful, accurate procedure.
Cover: Frank Cecala.

NOTEBOOK

- 899** Trustees' Report
- 902** UMDNJ Notes
- 903** MSNJ Auxiliary
- 903** SBME Update
- 904** New Members
- 905** Placement File
- 906** Statement of Ownership
- 909** Continuing Education

INNOVATIVE MEDICAL SYSTEMS, INC.

... Doing what **WE DO BEST**, so you
can do what you do best



THE IMS ADVANTAGE

- IMS has demonstrated its success by **INCREASING COLLECTIONS AND CASH FLOW WHILE ENHANCING THE PHYSICIAN'S PROFESSIONAL IMAGE**
- IMS is a fully **BONDED ORGANIZATION OF MEDICAL MANAGEMENT SPECIALISTS** with over 15 years experience in practice management.

FOR INFORMATION CONTACT: 609-770-1160
GLENDALE EXECUTIVE CAMPUS • 1000 WHITE HORSE ROAD
SUITE 512 • VOORHEES, NEW JERSEY, 08043

The Breathing Center



*Making
Your Job
A Little Easier*

Diagnosing and Rehabilitation Are Our Business... Let Us Assist You

The Breathing Center, a group of private medical centers specializing in diagnosing and rehabilitation of pulmonary disorders, has worked with hundreds of New Jersey physicians and helped thousands of their patients. We also specialize in sleep apnea evaluation services, assisting area physicians and health professionals.

Our assistance includes full diagnostic evaluation and rehabilitation of your patients. We return to your good care more manageable, knowledgeable and healthier patients with improved lifestyles and a decreased need for hospitalization. Pulmonary rehabilitation compliments your care.

Call our patient coordinator today for more information. In Northern New Jersey call our Morristown Center at 539-5330 or in Central and Southern New Jersey call our Edison Center at 417-9339.

Your patient need not be a Senior Citizen !

Many *UNDER 65* have a venous or arterial disorder.
For a *SAFE, NON-INVASIVE* and *RELIABLE* evaluation, information
or to make any appointments, call:

VASCULAR DIAGNOSTIC CENTER



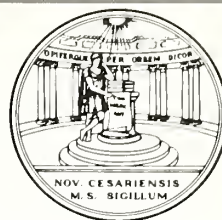
230 SHERMAN AVENUE • GLEN RIDGE, NEW JERSEY • 07028

(201) 748-5990

Physician consultation available

NEW JERSEY MEDICINE

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

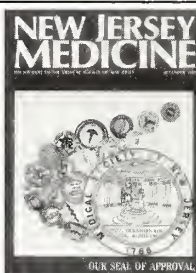


CONTRIBUTIONS

- 947** Asthma Due to
Parasitic Infestation
William D. Strazzella, DO
Benjamin H. Safirstein, MD
- 951** Lung Cancer:
Difference in Age
at Diagnosis
Perry A. Scheinok, PhD
Peter E. Engler, PhD
Patricia D. Robertson, BA
Robert V.P. Hutter, MD
Donald E. Henson, MD
- 959** Our Seal of Approval
Geraldine R. Hutner, MA
- 962** Euthyroid
Hypertri-iodothyronemia
Michael H. Goldman, MD
Darius S. Sypek, MD
- 965** Epidemiology of
Congenital Syphilis
Michael E. Petrone, MD, MPH
Mary J. Teter, DO
Clifford G. Freund, MPH
John Porter, MBBS, MPH
William E. Parkin, DVM, DrPH
Kenneth C. Spitalny, MD
- 970** Physician Service
to Afghan Refugees

DEPARTMENTS

- 929** MSNJ Newsletter
- 933** Professional Liability
James E. George, MD, JD
A. Ronald Rouse
- 935** President's Page
Paul J. Hirsch, MD
- 939** Editor's Desk
Howard D. Slobodien, MD
- 943** Book Reviews
- 972** MSNJ Liaison
Representatives
- 975** 1989 Index:
NEW JERSEY MEDICINE



The Cover: Over 200 years ago, MSNJ created its seal to represent the purpose and function of the organization.
Design: Robin Kennett.

NOTEBOOK

- 984** Trustees' Report
- 986** UMDNJ Notes
- 986** MSNJ Auxiliary
- 987** AMNJ Report
- 988** Placement File
- 989** Continuing Education
- 995** In Memoriam

NOW IS THE TIME TO MARKET YOUR PRACTICE.

We work with
both surgical and
medical specialties.

Call now
for FREE information:
Rebecca Anwar, Ph.D.
(215) 649-8770



Hoover Anwar Associates
Medical Marketing Services

First Pennsylvania Bank Building
Seven East Lancaster Avenue
Ardmore, PA 19003

**WHERE DO THEY GO WHEN YOU
TELL THEM TO LOSE WEIGHT?
TREAT THEM IN YOUR OFFICE**



State-Of-The-Art Supplemented Fasting Program

- Safe
- Medically Proven
- Simple
- Effective
- No Calorie Counting
- No Weighing Food
- No Measuring Food
- No Gimmicks
- No Shipping Costs
- Economical
- Convenient
- Sold To Physicians Only
- Physician Owned Company

For information, samples, or a free tutorial, call: 201-712-0909 or 800-333-9399. Medical Weight Management, Inc., 441 Market Street, Saddle Brook, N.J. 07662.

Thomas Haluszczak, Jr.
ATTORNEY AT LAW

DEBT COLLECTION
NORTHERN & CENTRAL NEW JERSEY
(201) 925-8133
Linden, N.J.

T H E V I T A L S I G N O F PHYSICIANS' INSURANCE



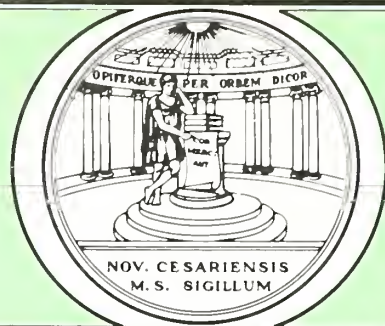
More NJ physicians choose MSNJ Group Health Care Plans than all other policies combined — because they know how vital quality health care insurance is.

- Blue Cross/Blue Shield and Major Medical Insurance
- Dental Insurance
- Long-Term Care Insurance

F O R M O R E I N F O R M A T I O N
CALL The Insurance Solutions People at 609 895-1616

DONALD F. SMITH & ASSOCIATES

MEMBERSHIP NEWSLETTER



M
S
N
J

THE MEDICAL SOCIETY OF NEW JERSEY

Volume 62

AMERICAN MEDICAL ASSOCIATION

Survey Advisory

The AMA will mail a questionnaire to a representative national sample of practicing physicians in an effort to determine precisely how third-party payor "prior authorization" and retrospective utilization claims review programs may be adversely impacting upon medical practice and clinical decision making and to what degree such programs have increased administrative pressures on physicians and their office staffs. The survey is being conducted by AMA's Council on Medical Service.

MEDICAL SOCIETY ON NEW JERSEY

Board Actions

Resource-Based Relative Value Scale Study. The first portion of the federally funded study undertaken by Harvard has been released. The Board of Trustees reviewed an AMA analysis. Some national specialty societies have indicated their support of the Harvard study. Since the full impact and complete analysis have not been done, the Board urges all county and specialty societies to reserve judgment. Action should be taken only when a complete study and analysis are available.

Reinsurance Surcharge Hearing. The insurance commissioner's malpractice surcharge proposal was discussed. Over 200 persons were in attendance. All speakers opposed the proposal. The Society will maintain its vigilance and continued opposition.

S-2936—Medical Discipline and Licensure Reform. This bill amends existing laws, increases reporting requirements consistent with federal statutes, and assures physicians of due process and fair treatment. The Society has offered modifications and amendments to the sponsor that will strengthen both the efficiency and fairness of the legislation. The State Board of Medical Examiners has taken a position of opposition and has requested that the Insurance Commissioner and the State Commission of Investigation join with it in opposing the bill. County medical societies and specialty societies are requested to give this bill very careful review, and to support the Medical Society of New Jersey position.

State Board Opinion on Percentage Rental Agreements. The Board reviewed an opinion letter issued by the State Board declaring a percentage fee arrange-

ment, based on gross income, between physicians and a hospital-owned corporation is within acceptable parameters of the State Board of Medical Examiners. That opinion conflicts with current ethical standards and, if followed, may be a violation of Medicare Fraud and abuse statutes. The Board has requested the State Board to reconsider that opinion.

Medicare Mandatory Assignment. A-2305 requires physicians to accept Medicare assignment. Assemblyman Alan Karcher made a motion to have the bill extracted from the Assembly Health and Human Services Committee. Assemblyman Chuck Haytaian opposed Mr. Karcher, and made a motion to table. The motion to table was approved. The Society continues its opposition to this legislation.

OPHTHALMOLOGY/OTOLARYNGOLOGY ACADEMY Award to MSNJ Staff Member

Marshall S. Klein, executive director of the New Jersey Academy of Ophthalmology and Otolaryngology, presented an award to Patricia Hackett, MSNJ staff member, at the annual fall meeting.



The plaque was presented to Mrs. Hackett in appreciation for coordinating the statewide Eye Health Screening Week and because of her tireless efforts in helping to prevent blindness in New Jersey.

SIDS RESOURCE CENTER Counseling Programs

The state's first Sudden Infant Death Resource Center now is operating and ready to offer counseling to grief-stricken parents of babies who have died as a result of Sudden Infant Death syndrome. Immediate telephone counseling is available via a 24-hour, toll-free hotline. The number is 1/800/545-SIDS.

FINI

"By working faithfully 8 hours a day, you may eventually get to be boss and work 12 hours a day."

CLARK MARTIN*

Politics Takes Center Stage; Midterm Report

POLITICS TAKES CENTER STAGE

Welcome to 1989, New Jersey's most political year since Brendan Byrne left the governor's office and 21 contenders entered the 1981 race to replace him.

We'll see the same level of activity this year. Like Byrne, Governor Tom Kean is barred by the state constitution from running for a third consecutive term.

Among elected officials, congressmen and state senators won't risk their current offices by running for governor. If they lose the gubernatorial race, they can continue to serve in the House of Representatives or the State Senate. But for assemblymen, the race for Governor is an all-or-nothing proposition because the entire 80-member Assembly is up for election this year as well, and candidates cannot run for both offices simultaneously.

Given these considerations, it's logical to expect more state senators and congressmen than assemblymen to enter the race. And that's apparently what we'll see. Among those currently testing the waters are Senators John Russo (D-Ocean), John Lynch (D-Middlesex), Richard Codey (D-Essex), Jerry Stockman (D-Mercer), William Gormley (R-Atlantic), Gerald Cardinale (R-Bergen), Leanna Brown (R-Morris), as well as Congressmen Jim Courter (R-12th District), Jim Florio (D-1st District), and Dean Gallo (R-11th District).

Planning to give up their Assembly seats to run for governor are two prominent assemblymen, Speaker Chuck Hardwick (R-Union) and former Speaker Alan Karcher (D-Middlesex). Both are well known to New Jersey's physician community; Hardwick for his strong support of medicine's side on a variety of issues, and Karcher for his unflagging efforts to enact mandatory

Medicare assignment. Add to the list such non-legislators as Attorney General Cary Edwards (R-Bergen), former Turnpike Chairman "Bo" Sullivan (R-Essex), and Princeton Mayor Barbara Sigmund (D).

MIDTERM REPORT

Medicare Assignment. Assemblyman Alan Karcher's A-2305 remains in the Health and Human Resources Committee. His motion to relieve the committee of the bill was "tabled" in an Assembly floor vote in October. Look for Karcher to make another attempt sometime before the June primary election; he's cultivating the senior citizen vote. Senator Carmen Orechio's identical bill, S-1649, remains in the Senate Health Committee.

Structured Payments. Senator Raymond Lesniak's S-1845, which would require judgments for future damages over \$250,000 to be paid in installments instead of a lump sum, has been pending a floor vote in the Senate for more than six months. If enacted, malpractice premiums could be reduced by as much as 10 percent. Powerful trial lawyer lobbies are fighting the bill.

Financial Disclosure. A bill recognizing the physician's right to own and operate services to which he refers patients—as long as he discloses that financial interest—was conditionally vetoed last month by Governor Kean. S-734/A-2485, sponsored by Senator Richard Codey and Assemblyman Chuck Haytaian, was returned to the legislature for concurrence in clarifying language. The bill should become law soon.

Disciplinary Proceedings. The product of a year's negotiations with sponsor Richard Codey, S-2936 would reorganize the Board of Medical Examiners to separate those who investigate complaints from those who ultimately decide guilt or innocence. The bill, pending committee consideration, reflects the Society's major response to the startling 1987 report of the State Commission of Investigation. That report charged that impaired and incompetent physicians go unreported and unpunished.

Physical Modalities. S-2509 and A-3166, identical bills by Senator John Lynch and Assemblyman Anthony Impreveduto, would prohibit physicians from allowing employees other than physical therapists to provide "physical modalities." The bills are dormant at the moment, but may pick up momentum in the wake of the Society's court win last month over a proposed regulation of the Board of Physical Therapy. The rule would have permitted PTs to examine patients, give instructions, and modify therapy treatments with no physician involvement.

Medical Waste. Last summer's hottest issue in the legislature lost its head of steam after Labor Day, and Congress eventually passed its Connecticut-New York-New Jersey law first. Now S-2343 is undergoing revision in committee.

Intrusions into Medical Practice. A bill licensing social workers as independent psychotherapists remains in Assembly committee following its passage in the Senate in June. S-1208 is sponsored by Senator Matthew Feldman. Senator Wynona Lipman's S-1018, which permits nurses to diagnose and prescribe medication, remains in Senate committee.

*Mr. Martin is MSNJ's legislative consultant.

Findings from the Court

Patient Sues Physician and Physician's Assistant; Child Cannot Sue for Wrongful Life; Legal Malpractice Case Results in \$95,000 Verdict

PATIENT SUES PHYSICIAN AND PHYSICIAN'S ASSISTANT

A patient was not required to provide expert testimony to counter affidavits by a physician and a physician's assistant as to the standard of care, a Georgia appellate court ruled.

On a Friday afternoon, when his regular physician was unavailable, the patient went to the office of the defendant physician and his assistant, complaining of abdominal pain he believed was appendicitis. The patient was seen only by the physician's assistant, whom he believed to be the physician.

The assistant examined the patient and made a diagnosis of epididymitis. He allegedly did not consult with the physician but gave the patient a prescription by filling in a blank form that had been presigned by the physician. He told the patient that he would feel worse before feeling better but would be able to return to work on Monday.

When the patient did not feel better on Monday, he went to another physician, who diagnosed probable appendicitis. The patient was referred to a surgeon, who operated and found a ruptured appendix and a severe infection.

The patient brought an action for malpractice against the physician and his assistant, alleging negligence in failing to diagnose and treat his appendicitis. The physician and the assistant filed affidavits stating that they had acted in compliance with the applicable standards of care for physicians and physician's assistants, respectively. They declared that the assistant had consulted with the physician regarding the diagnosis of the patient's condition and that the physician had concurred in the diagnosis and signed a prescription.

The trial court found that the patient had failed to introduce expert testimony and granted summary judgment for the physician and his assistant.

On appeal, the court said the evidence must be construed most strongly in favor of the nonmovant on the motion for summary judgment. Since the patient's evidence showed that the other parties' conduct did not comport with the standard that their own testimony showed to be applicable, the court found the trial court erred in granting summary judgment.

The court said that since expert testimony by the physician and the assistant had established the standard of care, there was no reason that only experts would be qualified to show whether the patient had been given such care.

The court said there also remained issues of fact whether, if the circumstances surrounding the patient's visit to the physician's office were those that his evidence showed, his subsequent suffering of a ruptured appendix and infection was attributable to factors other than his visit. The court found that the trial court erred in granting summary judgment on the proximate cause issue. (Reprinted from *The Citation* with permission, American Medical Association, 535 N. Dearborn Street, Chicago, IL 60610, June 15, 1988, Volume 57, Number 5)

CHILD CANNOT SUE FOR WRONGFUL LIFE

No cause of action existed for a claim of wrongful life on behalf of a child born after an unsuccessful tubal ligation, a Louisiana appellate court ruled.

A woman underwent a tubal ligation after delivery of their second child because she and her husband decided that it was not economically feasible to have more children. Nevertheless, the woman conceived and gave birth to a third child. The child was afflicted with albinism.

The parents sued the physician who performed the tubal ligation and the hospital, seeking damages on the child's behalf for wrongful life and on their own behalf for wrongful conception, or wrongful birth. The trial court denied a motion by the physician and hospital to dismiss, and they sought review.

The court said that in order to find that the child had been damaged by her birth it must be said that it would have been better if she had not been born at all. Since the court could not say this, it could not award damages for wrongful life. The court held that such an action did not exist in the state.

The court said that if the physician and hospital were found guilty of malpractice as alleged, they must respond in damages for expenses incurred as a result of the pregnancy and delivery. The parents claimed damages for emotional and mental distress resulting from the unexpected conception and birth of an unwanted child, the enlargement of family responsibilities, and the diminished ability to devote time to the rearing of the other children.

The court said such interests were not protected by state law. The court found the mother could seek dam-

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are Director of the Department and Director of Special Projects, respectively.

ages for the wrongful conception of the child and for expenses incurred during pregnancy and delivery. The father could seek damages for loss of consortium, service and society, and expenses incurred during the pregnancy and delivery and postdelivery. The court sent the case back to the trial court for further proceedings. (Reprinted from *The Citation* with permission, American Medical Association, 535 N. Dearborn Street, Chicago, IL 60610, June 15, 1988, Volume 57, Number 5)

NEW JERSEY LEGAL MALPRACTICE CASE RESULTS IN \$95,000 VERDICT

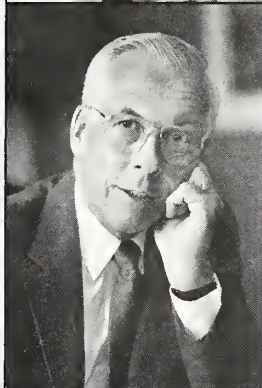
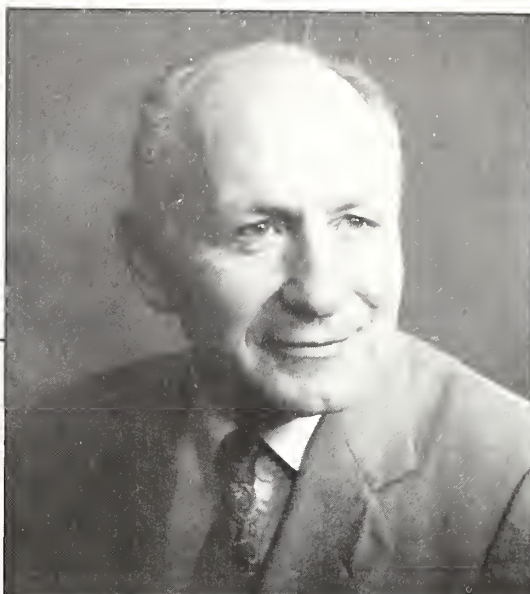
This was a legal malpractice/wrongful-birth action in which the plaintiff contended that the defendant attorney failed to timely file a medical malpractice action against the underlying defendant who allegedly deviated in the performance of a tubal ligation, resulting in an unwanted pregnancy. The alleged damages were limited to the emotional and physical pain and suffering stemming from the pregnancy and birth itself. The defendant, who did not file the action, had contended that no grounds for the malpractice action existed. The plaintiff's legal expert contended that the defendant should have filed the action within the statute of limitations, or should have advised the plaintiff regarding the chances of success of the malpractice action within a time frame which would have enabled her to seek alternative counsel.

The plaintiff had three prior children and approximately three years after the alleged medical deviation, she became pregnant with her fourth child. On the day of delivery of the third child, the plaintiff underwent the tubal ligation which she contended was negligently performed. After the subsequent pregnancy, the plaintiff underwent a second ligation. This final procedure was performed by the physician testifying in the instant case as the defendant attorney's medical expert. The operative report taken by the physician who performed the first ligation could not be located. An employee of the nonparty hospital testified that either the physician did not dictate the report, or that it had been misplaced during transfer to microfilm. The plaintiff's expert obstetrician/gynecologist utilized the operative report prepared by the defendant's expert during the subsequent ligation in which he described his findings regarding the earlier ligation, as a basis for his conclusion that the initial ligation was improperly performed. The plaintiff's expert indicated that the right tube had been interrupted in the distal third, which was proper, and that the left tube was interrupted immediately below the "fimbriated end, proximal." The plaintiff's expert contended that this left side procedure constituted a partial "fimbriectomy" which was insufficient for this plaintiff. The defendant's expert who had prepared this report disputed the plaintiff's expert's interpretation of the records and his conclusion, contending that the interruption in this area was proper. The defendant's expert contended that 4 percent of the ligations fail despite proper technique by a physician.

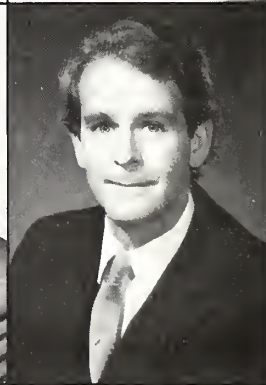
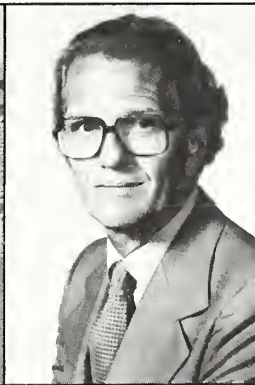
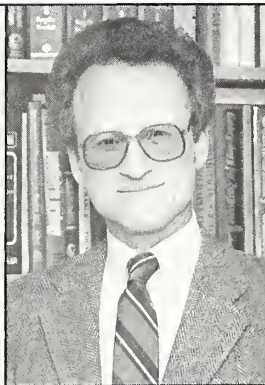
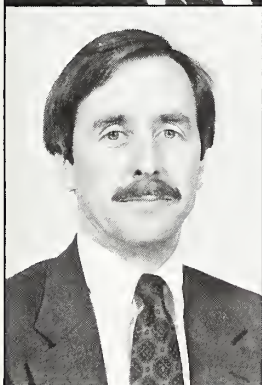
The plaintiff related that when she decided to under-

go the ligation during her third pregnancy, she was in the process of divorcing her first husband, who had beat her when she was pregnant, and was on welfare. The evidence revealed that the first husband was not the father of this child several years after the birth. The plaintiff contended that her third child had reached school age, allowing the plaintiff to return to work, and that shortly after she had returned and was able to go off welfare, she was informed that she was pregnant. The plaintiff indicated that she suffered severe morning sickness, was unable to work after the first trimester, and that she was required to remain on welfare for the next four years while caring for this child. The plaintiff's claim for damages related to the period during the pregnancy because she greatly desired to be self-sufficient. The plaintiff additionally contended that the last several months of the pregnancy were complicated and that she was required to rest extensively. There was no proof that either she or the baby were in danger. The jury found that the defendant attorney was negligent, that the physician performing the ligation in the underlying case was negligent, and awarded \$95,000.

Commentary. In this legal malpractice action, the plaintiff, in addition to establishing negligence on the part of the defendant attorney, was required to prove the components of the underlying medical malpractice case to establish proximate cause against the defendant attorney. The inability to produce the physician's operative summary significantly undermined the defendant's case and was undoubtedly a major factor in the result, notwithstanding the defendant's endeavors to overcome this problem by presenting the physician who performed the second ligation, who opined that the prior procedure was performed properly. Additionally, the status of the case as a legal malpractice action may have rendered the jury more amenable to the plaintiff's claims on the underlying action and rendered it less difficult for the plaintiff to obtain a verdict. Regarding damages in this wrongful birth case, the court instructed the jury that the plaintiff could only recover medical expenses attendant to the pregnancy, which were stipulated at slightly more than \$2,000, and for her pain, suffering, and emotional distress during the pregnancy and birth. The plaintiff, who already had three children and had previously been on welfare, emphasized that she greatly desired to cease obtaining welfare, had finally regained her self-sufficiency by commencing work only one month before she learned she was pregnant, and was required, because of the pregnancy, to cease working and return to welfare, causing extensive anguish during this period. The plaintiff, who was confronted with the difficult situation of alleging negligence resulting in her giving birth to a child, stressed that although she loves this child greatly, the damages were being sought for her anguish during the pregnancy itself, and that the jury should view the case from the perspective of the plaintiff during this period and the impact that the necessity of returning to welfare had on her at that time. (*New Jersey Jury Verdict Review and Analysis*, May 9-May 23, 1988, Volume IX, Issue 1).



This special issue on biomedical ethics was a year in the making. We were prompted into action by the challenge of the biomedical ethics issue. Effort and progress will be required by all concerned to achieve direction and meaning for the future of medical ethics. The contributors to the special issue on biomedical ethics are (clockwise, from top center): Joseph F. Fennelly, MD, guest editor; Heather Marie Smith; Palma E. Formica, MD; Anne R. Somers; Paul W. Armstrong, JD; Stanley S. Bergen, Jr, MD; Robert L. Pickens, MD; Cheryl J. Tice; Robert C. Cassidy, PhD; Kopel Burk, MD; James S. Todd, MD; and D. Marlene Caruso, RN, MSED. Unavailable for photographs were B.D. Colen; T. Patrick Hill; Mary S. Strong; and Patricia Murphy, RN, PhD.



We're putting lives back together.

As a physician you've probably seen it. A family's struggle against alcohol or drugs. A man or woman afraid to ask for help in dealing with depression. A young girl hiding an eating disorder behind a smiling face or popular personality.

At the Carrier Foundation, we work with physicians in treating troubled adolescents and adults. Unlike most general hospitals, all our resources are dedicated to this mission. And have been for more than seventy-five years.

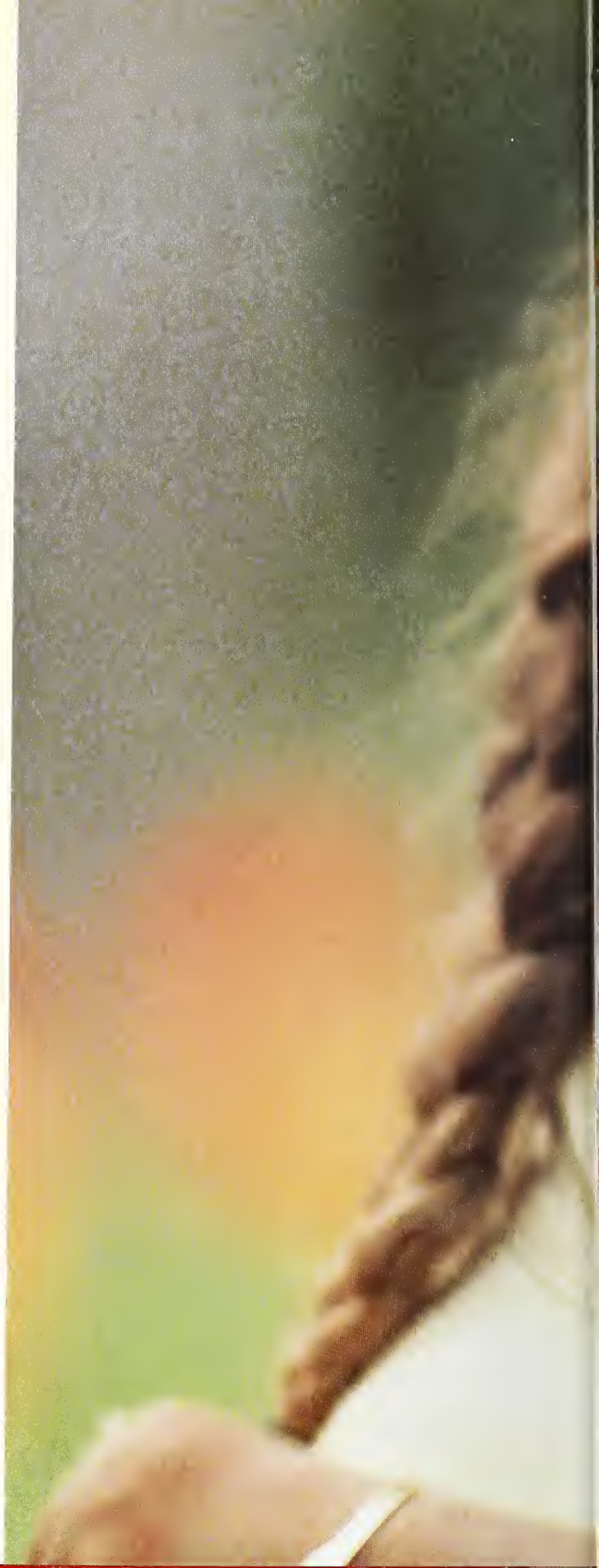
Recognized by all major insurance companies, Carrier is a private, non-profit psychiatric hospital providing both inpatient and outpatient programs. Some of Carrier's specialized programs include: addiction recovery service, adolescent program, affective disorders program, behavioral therapy, eating disorders program, family therapy, geriatric program and women's program.

For more information, call the Carrier Foundation at 1-800-223-0207. The Carrier Foundation. We're putting lives back together.



Carrier Foundation

Belle Mead, New Jersey 08502



Ethics or Enigmas?

HOWARD D. SLOBODIEN, MD

The governor signed the bill authorizing death by injection. What does the Medical Society of New Jersey (MSNJ) think about this? So began a long series of newspaper, radio, and television interviews for the newly inducted president of MSNJ. The Society recommended that physicians, dedicated to the preservation of life, should not be active participants in legal executions, although they might continue to perform medical duties, such as pronouncing death or checking physical status.

This policy, fairly bland and straightforward, aroused considerable opposition. Some doctors said they would be very happy to give the injection. Other individuals asked, "If doctors are so interested in preserving life, how can they perform abortions?" A necessary contemplation of these and other issues changed my casual interest in medical ethics into a deep and abiding one, and stimulated the establishment of the Bioethics Committee of MSNJ, with David Eckstein, MD, a kind and compassionate geriatric specialist, as the chairman.

Since then, interest in biomedical ethics has increased tremendously, paralleling the increase in

technologic and scientific advances. Unfortunately, we seem to generate many more questions than answers. Much of the discussion centers in three areas:

- *Reproduction and Genetics.* The entire abortion issue is included in this area; the ethics of denying Medicaid funding is a small part of the discussion. The propriety of surgery on the fetus or the use of fetal parts generates controversy. Who determines the proper limitations of treatment in the severely handicapped newborn?

- *Death, Dying, and Competency.* This area receives the most attention as we wrestle with many opposing ethical and legal pronouncements. Under what circumstances do we "pull the plug?" Does the use of feeding tubes and intravenous solutions represent the application of "extraordinary measures?" At what point should treatments with marginal benefits, e.g. chemotherapy and surgery, be denied? Can we agree on the appropriateness of euthanasia, active or passive, when we have trouble in defining its terms? Does abortion on demand differ from active euthanasia?

- *Patient and Physician Rights and Autonomy.* The lines are difficult to draw, although the courts continue to impose their will, albeit in varying directions. We certainly are much more open in discussing diagnoses, prognoses, risks and benefits of treat-

Dr. Slobodien is editor-in-chief, *NEW JERSEY MEDICINE*. Requests for reprints may be addressed to Dr. Slobodien, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648.

ment, and alternatives to care; this is a welcome change, despite valid concerns about the extent of such disclosures. It is more difficult to handle the confidentiality aspect of the physician-patient relationship, especially where public health matters are involved; HIV testing is one example of a problem area. We also tend to agree that the patient should have free choice of doctor and facility; how does this fare in the face of efforts to promote managed care? Finally, if the patient has the right to withhold recommended treatment, is he/she committing suicide? Should suicide be legalized?

Many other areas also deserve deep consideration, even though "final" answers seem to have been given in some instances:

- *Advertising.* It is clear that antitrust decisions have opened the floodgates for those hawking their wares. Patients are promised same-day surgery, even when it is agreed that many will remain hospitalized. Patients are promised "no out-of-pocket expenses," even though federal law mandates otherwise. Hospital is pitted against hospital. If we concede the legality of most of this advertising and simultaneously ignore any changes in the professional images of the advertisers, can we also find increased benefits for the patient, in quality of care and in cost? Are those who spend large amounts of money in an attempt to sell surgery able to judge objectively who needs surgery?

- *Physicians as Corporate Employees.* The practice of medicine in New Jersey has long been restricted to physicians and to hospitals. Now we have a contrary and disturbing opinion from the State Board of Medical Examiners. In response to a query from a representative of a Pennsylvania corporation, the Board rescinded its previous disapproval of arrangements involving the payments of a percentage of revenues rather than a flat fee for specific services given by the corporation. The threat to professionalism and to independent judgment for the benefit of the patient should be clear. What comes next?

- *HCFA and Mortality Figures.* What can one say regarding the ethics of releasing data known to be flawed, regardless of the impact on the involved? How can a responsible agency cite practitioners for medically unnecessary services, when it offers no criteria on which to base such decisions? How can it certify the activities of its PRO and renege on them on review?

- *Resource-Based Relative Value Study (RBRVS).* This study has the potential for splitting asunder the medical profession. Some specialties, somewhat prematurely, already have taken positions favorable only to themselves. Governmental officials concede RBRVS will not decrease the overall costs of medical care. Yet, the study measures

only resource inputs. The benefits of service are not measured; neither are the relative pressures on the physician nor the risks of treatment, cognitive or procedural, to the patient. How much importance shall we give to such a report? Are liability insurance companies' risk classifications to be ignored?

- *Media and Medicine.* Sensationalism sells stories. We could hope for balanced reporting. The physician and the patient suffer from this irresponsibility. Is the term journalistic ethics an oxymoron?

- *Single-tiered Health Care.* This is a favorite avowed goal of politicians and naive health-care economists. It should be clear that people with money always can buy more, if not better, health care. Those who develop entitlement programs know that criteria must be set to determine who is entitled, i.e. means tests, although espousing this notion could be political suicide.

- *Allocation and Rationing.* These activities, by government, by insurance companies, and by gatekeepers will be the next major item on the list of ethical debates.

- *Religion, Society, and Morality.* What is "right" and what is "wrong"? How do we protect the rights of the majority and the minority? Is a teleologic approach adequate?

- *Legislatures and Courts.* Is morality a prime issue in these venues? Can all agree that money problems are best left to the patient, the patient's representative, and the physician?

The Citizens Committee on Biomedical Ethics in New Jersey is following in the footsteps of Oregon Health Decisions, formed by my medical school classmate, Ralph Crawshaw. The Committee is attempting to get citizens involved in health care problems, to understand and to consider the ethical issues underlying health care, and to participate in and stimulate health-care decisions.

There is difficulty in deciding who should be called an ethicist. The study of philosophies or societies may help to categorize and define the problems of medical ethics; the study of religions may do likewise. But these studies are not sufficient, by themselves, to reconcile all the differences—philosophic, religious, or sociologic—that have divided even the most ethical among us for thousands of years. Yet, we must search for solutions. More physicians and nurses should be involved; they are the ones in the trenches.

We hope this issue of *NEW JERSEY MEDICINE* will stimulate you to enter the fray. We must not default this responsibility. And we should all heed Dr. Eckstein, who is sorely missed, and who advised us, "When caring for the patient, one should do the best one can, not the most." ■

A Time of Change

JOSEPH F. FENNELLY, MD

One does not need miraculous insight or a crystal ball to understand that today, the medical profession is living in the best of times and the worst of times. The general health of the population and its expectations for longevity never have been higher.

We chose to invest a staggering sum of money into our national health care delivery system over the past two decades in an effort to expand, to extend, and to improve it. The capabilities of the dedicated medical professional are at an all-time high.

It is one of the most noteworthy ironies of our age that these same accomplishments, in a very real sense, are at the root of the problems that make this also the worst of times. As miracles of medical technology explode into public view at an ever-increasing rate, people have come to expect them, and to take such miracles for granted. Death and incapacitation no longer are results of accident or disease, but are failures, where someone must be at fault, and must be made to pay for the error.

The ability to prolong life has raised new questions of life and death. Is being alive enough, or is the quality of that life also an issue? Physicians now have to learn to deal with the even more difficult and very unpleasant questions raised by a potential death. In an era where the ability to save and heal has outstripped the resources available to do so, harsh decisions must be made.

In the United States, the doctor's bill has become significant and the enormous investment in the health care profession has come under much scrutiny. Physicians have difficulty understanding and coping with a cost-conscious approach to medicine.

All of these changes may boil down to the most fundamental change of all: society's demand that it be included in a physician's professional work. This is expressed in guidelines and restrictions from government bodies and third-party payers, and it is Dr. Fennelly is guest editor of this special issue. Requests for reprints can be addressed to Dr. Fennelly, 8 Shunpike Road, Madison, NJ 07940.

becoming an intimate part of medical practice.

Today, it is not enough to have a diagnosis, prognosis, and a proposed course of treatment. Vigorous questions about these and every aspect of illness and treatment are being raised by patients and families. They demand to know what is happening, and also wish to participate in the decision making that flows from those findings. Much of this involvement is not the benign acceptance it once might have been, but reflects the skepticism and hostility with which many people view institutions of any sort.

Whether one sees this development as the intrusion of aggressive and poorly informed people into a highly technical area, or the legitimate concern of people for their welfare, does not alter the fact that the relationship of society and the medical profession has changed. Not only is it impossible to turn the clock back, but no sensible practitioner would voluntarily forego the new tools of healing in exchange for a more "civilized" discourse. The people will have their way—their questions will be answered, they will have a say in the disposition of their case and in the treatments used, they will decide what health care is worth, and they will tell us how much they wish to spend on medical care. The question we have to answer is the extent to which we are going to participate in those decisions.

The articles in this special issue address one of the most visible, high-impact points of this new and unexpected partnership: biomedical ethics. The decisions involved in this critical area are among the most difficult and complex we face. It is in this vital field of true life and death that the interests of the professional and the layman overlap, and a constructive dialogue must be maintained. You may be surprised at some of the people you meet on these pages, but that is done deliberately.

The problems physicians face in the area of biomedical ethics are enormous. If others can and will help solve them, we would be worse than foolish to ignore their offer of help. If partnership is part of the dilemma, it may be part of the solution as well. ■

MSNJ and Biomedical Ethics

PALMA E. FORMICA, MD

Ethical issues confront clinicians on a daily basis, with a magnitude I never expected to encounter during my career. There are no more complicated and stressful issues than those centered in the biomedical field regarding life, death, transplantation, and other heroic measures. New Jersey, of course, has led the national focus and debate on many of these, from the care of Karen Ann Quinlan, through the care of Conroy, Jobes, Farrell, and Peters.

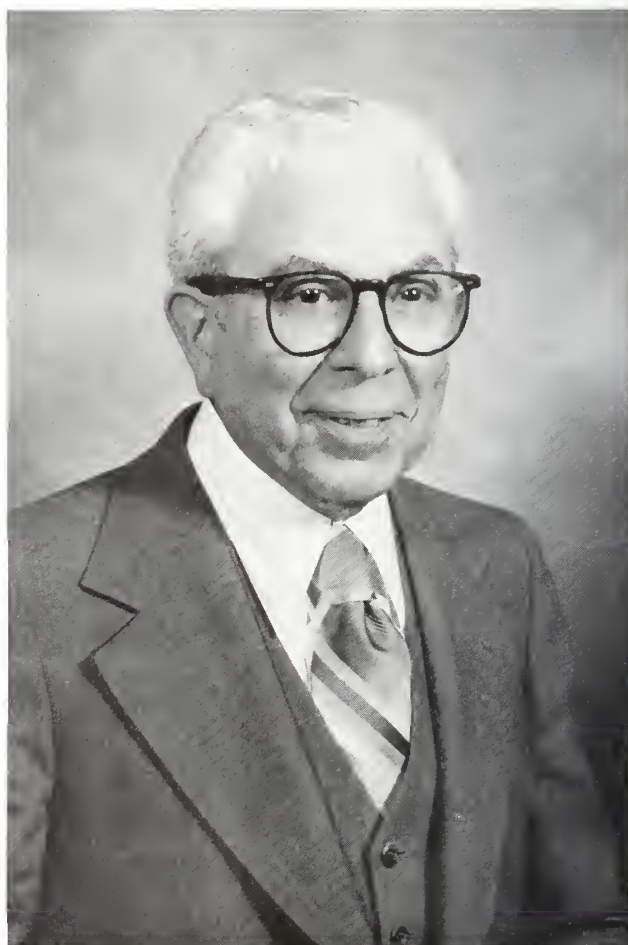
The University of Medicine and Dentistry of New Jersey made national headlines with the birth of a baby by means of in vitro fertilization. The saga of Baby M, its controversy, tragedy, and pathos have been with us for several years.

Readers of the *Journal of the American Medical Association* are aware of the argument over the publication of "It's Over, Debbie" and the refusal of the *JAMA* editor to identify the author. On March 19, 1988, a judge of the circuit court of Cook County granted the AMA motion to quash a subpoena issued by the district attorney to compel discovery of the name of the author.

The Medical Society of New Jersey, in an effort to assist its members, has created a Committee on Biomedical Ethics to advise us on these issues, and the editor-in-chief of *NEW JERSEY MEDICINE* is devoting this entire issue to the topic. A major achievement of the Committee was the development of a supportive care plan for nursing home patients. I am proud of that result, and I am sure that all of us will benefit from the perusal of that document

and the exciting and stimulating articles in this issue of *NEW JERSEY MEDICINE*.

We dedicate this issue to the late David Eckstein, MD, the first chairman of the Committee on Biomedical Ethics. ■



Dr. David Eckstein

Dr. Formica is president, Medical Society of New Jersey (MSNJ). Requests for reprints can be addressed to Dr. Formica, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

The Courts and the PVS Patient

PAUL W. ARMSTRONG, JD
B.D. COLLEN

On a rainy October morning in 1975, reporters fought for scarce seats in the magnificent ceremonial courtroom of the 150-year-old New Jersey Superior Court building in Morristown. Before a chancery judge used to determining routine matters of guardianship and contract law, attorneys for a father prepared to plead that he could advance his vegetative daughter's constitutional and common law rights to refuse what was believed to be life-sustaining medical treatment.¹

As a case of legal and media first impression, the saga of Karen Ann, Joseph, and Julia Quinlan was guaranteed minutes each night on network newscasts, as well as front-page coverage in newspapers around the world.² In advancing their daughter's constitutional right to privacy, an American family lost all of theirs. And, unfortunately, it was necessary for them to do so. In order for the public to

understand issues that up to that time had only been debated in hospital corridors and forums such as *The Center Report*, it was necessary for Karen Ann's parents to fully explain themselves to the world: it was not, they maintained, that they wanted their daughter to die; they wanted her freed from the tyranny of the machine thought to be maintaining her life past the point at which she would have wanted to live. (She died on June 11, 1985.)

Eleven years later, when in re Nancy Ellen Jobes was filed in the same courthouse, there should have been a pandemic of media and public déjà vu.³ Here was yet another unfortunate young woman in a persistent vegetative state (PVS). Again, a family, this time led by a 29-year-old husband, was in the same courthouse asking a different chancery judge for the same relief. The challenged modality this time was a feeding tube, rather than a Bennett MA-1 respirator, but the issue was identical: physicians and health care facility administrators were refusing to allow the withdrawal of life-supporting medical technology from a patient for whom the treatment offered no hope of improvement—to say nothing of recovery.

Beginning with the New Jersey Supreme Court in the Quinlan case, court after court, commission after commission, and even some legislatures, have affirmed and reaffirmed the right of an incompetent patient—particularly a patient in persistent vegetative state—through family members and guardians, to refuse life-sustaining medical treatment. Why, then, has it been necessary for the Jobeses, the Brophys,⁴ and other families to go through the same

The authors wish to dedicate these remarks to the memories and families of Karen Ann Quinlan and Nancy Ellen Jobes and to Ms. Quinlan's caregivers at Morris View Nursing Home, Morris Plains, and the caregivers of Mrs. Jobes at Morristown Memorial Hospital, for their courage and example. Paul W. Armstrong, JD, LL.M., is vice-chairman of the New Jersey Bioethics Commission; he represented the families of Ms. Quinlan and Mrs. Jobes before the courts of New Jersey. B.D. Colen is science editor, *Newsday*, cowinner of the 1984 Pulitzer Prize for coverage of the Baby Jane Doe case, and author. The views expressed here do not represent those of the New Jersey Bioethics Commission or *Newsday*. Requests for reprints can be addressed to Mr. Armstrong, 1051 Tall Oaks Drive, Bridgewater, NJ 08807.

public hell endured more than a decade earlier by the Quinlan family? Why have physicians and health care administrators been unwilling to accept the professional freedom and responsibility given them by courts, legislatures, and public opinion polls? Even more puzzling, why have they so often ignored the ancient admonition to first, do no harm? And surely maintaining what only a vitalist would call the "life" of a Karen Ann Quinlan, Paul Brophy, or a Nancy Ellen Jobes, does such a patient no discernible good and causes great harm to all those who loved those patients when they were able to benefit from that love.

Why, 11 years after Quinlan, was there such media interest in the case of Nancy Ellen Jobes? The question, really, is not why the media seemed so intrigued by the case, but why was there a case in the first place? The New Jersey Supreme Court settled these matters in the Conroy⁵ case a year earlier.

The answer to the question—why the media interest—is easy and obvious: the Jobes case involved a formerly attractive, vital, young woman, who, after her fetus was killed in an auto accident, was herself made vegetative by a physician's gross error. The young woman had a handsome, personable husband who loved the young woman who his wife had been and, at the same time, was honest enough to admit that, after six years of watching the body of his wife literally vegetate, he wanted to get on with his life. Then there were the articulate and obviously distraught parents, Eleanor and Robert Laird, who fully supported the action brought by their son-in-law. They and several of Nancy's friends and other family members concurred with Nancy's husband in his statements that Nancy had said repeatedly that she would rather be dead than ever have to "live" like Karen Ann Quinlan. To top it all off, here was a case in which the "right-to-life" movement was fully involved in advising and helping with the representation of a health care facility treating a PVS patient. How could the press have stayed away?

Why was it necessary for family after family, in state after state, to continually retread such well-trodden, yet always emotionally, financially, and even physically burdensome, legal ground?

In the first place, the myth of the incarcerated physician and the specter of the large civil verdict haunt our nation's intensive care units. We have been told by intensivists that nothing would please them more than being able to honor advance patient directives—and the requests of surrogates—to end life-sustaining treatment, but they simply cannot do it. They then explain that if they turn off a respirator before a patient is brain dead, they will be charged with homicide. It does not seem to matter that this

has only happened once in the entire history of American jurisprudence and, in that case, the indictment was quashed prior to trial.⁶ Similarly, these physicians are convinced that the very family members begging them to withdraw treatment will later file a multimillion dollar malpractice suit charging that the helpful physician brought about the untimely death of his patient. The truth, of course, is that no such suit has ever been filed, and there now are several cases pending against physicians who refused to honor surrogate decisions made on behalf of incompetent patients.^{7,8}

When asked why he won't ever turn off a respirator unless a patient has been declared brain dead, one intensivist responded:

In my view there's no way that I personally, ethically, medically, or as an agent of the hospital, can be party to that without a legal decision. No matter what my personal feeling, my personal beliefs, my personal bias, and my own strong feeling about a living will, it has nothing to do with it. It has to do with my own sense of priorities and my own sense of legal responsibility and legal culpability, and the impact it could have on me personally, the hospital, and my family. It could come to that. The system is so bizarre that a personal decision made by me may be attributed to me and I may be held personally liable and my family therefore would not only be affected indirectly, but directly, because my assets could become an issue. I see the worst possible case scenario in everything that I do.

Yet, this physician has his own living will: "I don't want my family being bled to death financially," he said. "I don't want them agonizing for weeks or months over me as a vegetable—and you can document this because you have it on tape! It's a duplicity of thought, but it's a fact."⁹

The second aspect of this problem is that while courts have ruled on these issues on numerous occasions, they repeatedly have pleaded in vain for legislatures to provide specific guidelines for families and physicians at the bedside. While 39 states have passed advance directive legislation, none of those laws provides a comprehensive framework for decision making from the nursery to the nursing home. Despite lengthy, thoughtful opinions from the New Jersey and Massachusetts state supreme courts, the diligent work of a Presidential commission,¹⁰ the issuing of federal Baby Doe regulations,¹¹ and the opinions of the American Medical Association's Council on Ethical and Judicial Affairs,¹² physicians

and families wrestling with these difficult questions are forced to wander a frequently forking road with, at best, confusing directional signs. The recently released *Guidelines on the Termination of Life-Sustaining Treatment and Care of the Dying*, prepared under the aegis of the Hastings Center by a multidisciplinary panel, provides what may prove to be the mold that finally gives useful form to the amorphous mass of previous work in this area.¹³ These guidelines may cover familiar territory in a unique way by laying out for families, health care providers, and society the ethically acceptable options for dealing with the major dilemmas posed by life-sustaining technology.

No where are these guidelines more desperately needed than in dealing with the thorny questions raised by the decision to withdraw care from PVS patients. From a purely scientific point of view, these patients should be the easiest to deal with, as a PVS patient is totally devoid of those qualities and abilities we associate with personhood: they cannot and will not ever again be able to see, hear, speak, respond, think, or feel on even the most rudimentary level.¹⁴ They are not, as those in the "right-to-life" movement would have us believe, handicapped or disabled. These are not patients with diminished capacity; they are unable to give or perceive love even on the most primitive of levels. They are nonmentative organ systems, artificially sustained like valued cell lines in cancer laboratories.

Ironically, it is all these things that make treatment decisions regarding PVS patients so difficult. For if ever there is a slippery slope, its top lies at the entrance to the PVS patient's hospital or nursing home room. How easy, for some, to write off these patients as nonhuman. How easy to argue that these patients are not worth the expenditure of our valuable medical resources. How easy to turn them into Willard Gaylin's neomorts,¹⁵ human organ farms in an age of organ shortages. How easy to decide that these are the cases that justify active euthanasia. But an acute awareness of the very vulnerability of these patients often leads to an unwillingness by physicians and other care providers to "give up" on those in PVS—even when the caregivers know intellectually that neither the patients nor their families are benefiting from treatment. Thus, we so often have otherwise rational, intelligent health care professionals insisting that PVS patients "respond" to their loving ministrations. Even when repeated tests and observations by internationally renowned PVS experts will prove a Nancy Ellen Jobes utterly devoid of any cognitive function, some nurse's aide will insist the patient smiles for her. After all, could those who see to the basic needs of PVS patients rationalize the hours, days, weeks, and months of

physical drudgery if they did not convince themselves that the patient was somehow appreciative?

Further complicating the issue is the fact that many PVS patients survive for long periods of time without mechanical ventilation.¹⁶ Thus, the question with these patients is whether the continuation of artificial nutrition and hydration is medically indicated. Those with experience caring for individuals in PVS must ask themselves whether the patient is benefiting in any way from nutritional support. Unless the caregiver is a vitalist, the answer is quite clear: providing artificial sustenance to such a patient may be of psychological benefit to the caregiver, and, under certain circumstances, may benefit family members, but it in no way benefits the person the patient used to be. However, withdrawing artificial nutrition and hydration appears to be an extremely psychologically difficult thing for many health care professionals to do. Because we refer to this artificial support as feeding, and because, as A.J. Levinson, executive director of Concern for Dying, put it, feeding "is a ham sandwich, a milkshake, or ginger ale,"¹⁷ the very idea of withdrawing such basic humane support goes against the grain not only of most physicians, but of many laypersons as well.

However, one of the reasons the idea of stopping "feeding" causes such revulsion in people, is the myth of the starving patient. Some in the "right-to-life" movement have worked long, hard, and successfully to create a false belief that to withdraw nutrition and hydration is to "condemn" a patient to a horrible, painful, and grotesque end.^{18,19} Nothing could be farther from the truth. In the first place, the PVS patient has no capacity to perceive pain. If there is no perception of pain, then certainly there is no perception of what the conscious patient would describe as hunger or thirst. To support this assertion, we have only to look at the experiences of the Brophy and Jobes families. In each of those cases, all nutrition and hydration were withdrawn after final adjudication. And, in both those cases the dying and deaths of the patients were peaceful and quiet. With the complete support and backing of staff members at two caring and courageous institutions, family members were able to maintain vigils for the less than two weeks it took Paul Brophy and Nancy Ellen Jobes to die. There were none of the signs of pain and suffering predicted under oath in court. In each case, the patient quietly slipped away as remaining organ systems failed.²⁰

However, the fact family members will witness a peaceful death if nutrition and hydration are withdrawn from the PVS patient, should not make us any quicker to give up on such patients. Until and unless society as a whole decides differently, if we

are to avoid sliding down that proverbial slippery slope, we must always maintain an acute awareness of the special vulnerability of the PVS patient. However, physicians cannot allow themselves to be paralyzed by this awareness. Treatment decisions should be made for the PVS patient as they would be for any other critically ill individual: the governing ethos must be whether the treatment's potential benefit outweighs its burden—be that burden physical, emotional, and/or financial. The question of benefit versus burden must be answered by the patient—in an advance directive—or by the patient's surrogate, *not* by the physician or institution. Physicians must never forget in these cases, as in all others, they are at the bedside to provide their best professional advice to the patient, not to make decisions on the patient's behalf. They also must realize that it is long past time to remove the process of decision making from the courtroom and return it to the hospital corridors and patient rooms where patients, families, and physicians traditionally worked out these problems. The courts have done their job: in Quinlan, Brophy, and Jobes the decisions clearly state that courts do not exist for the purpose of making treatment decisions. They are available if there is an otherwise insoluble disagreement over the propriety of a decision. But in each of these decisions the courts have stated clearly that the patient or surrogate, rather than the court or the physician, is the ultimate decision maker. Additionally, in Jobes, the court tells us that surrogates do not have to prove what the incompetent patient would want, but, rather, applying the principle of

substituted judgment, should act in accordance with what good faith understanding is of the patient's view of these matters.

Physicians and hospital administrators repeatedly have forced these cases into court, begging for guidance and freedom from civil and criminal liability. They repeatedly have been given both the guidance and the mantle of legal protection, and have been given it in such a way that they can return to the bedside and resume their traditional role. If they continue to rush to court every time they are confronted by an ethically hard choice, it becomes more and more likely that they will not like what they are told.³ While we may not agree with his views on the relative role of physician decision making and patient autonomy, we would all do well to remember the admonition issued shortly after the Quinlan decision by C. Everett Koop, "There is no way that there can be a set of rules to govern this circumstance. Guidelines perhaps are possible, but not rules. I can think of no more tragic circumstance to come on the practice of medicine, and no more tragic circumstance for a future patient to face than to have a legal decision made by someone in the field of jurisprudence who has not lived through these circumstances, and who could not in a lifetime of testimony understand what the problems are and how they should be handled. His training, his experience, and his emotions have not been intimately involved with similar circumstances in the past where his decision and his decision alone is the one that must answer all the questions, no matter how inadequately."²¹ ■

REFERENCES

1. Quinlan J, Quinlan J: *Karen Ann: The Quinlans Tell Their Story*. New York, NY, Doubleday & Company, Inc., 1977.
2. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied sub. nom., *Garger versus New Jersey*, 429 U.S. 922 (1976).
3. *In re Jobes*, No. 108-109, slip. op (N.J. June 24, 1987).
4. *Brophy versus New England Sinai Hospital Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986).
5. *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).
6. *Barber versus Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (Ct. App. 1983).
7. *Leach versus Akron General Medical Center*, 68 Ohio Misc. 1, 426 N.E.-2d 809 (Com. Pl. 1980).
8. *Estate of Leach versus Shapiro*, 13 Ohio App. 3d 393, 469 N.E.2d 1047 (Ct. App. 1984).
9. Colen BD: *The Essential Guide to a Living Will*. New York, NY, Pharos Books, 1987.
10. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research: Deciding to forego life-sustaining treatment. Washington, D.C., Government Printing Office, 1983.
11. *Child Abuse and Neglect Prevention and Treatment*, 45 C.F.R. Sections 1340.1-1340.20 (1986).
12. AMA Council on Ethical and Judicial Affairs and Judicial Council op. 215, March 15, 1986.
13. Hastings Center: Guidelines on the termination of life-sustaining treatment and the care of the dying, 1987.
14. Plum F, Posner J: *Diagnosis of Stupor and Coma*. Philadelphia, PA, F.A. Davis Co., 1980.
15. Gaylin W: Harvesting the dead. *Harper's Mag*, September 1974.
16. McWhirter N: *The Guinness Book of World Records*. New York, NY, Bantam Books, 1981.
17. Colen BD: *Hard Choices—Mixed Blessings of Modern Medical Terminology*. New York, NY, G.P. Putnam's Sons, 1986.
18. Lynn J, Childress J: Must patients always be given food and water? *Hastings Center Report*, 1983.
19. Paris JJ, McCormick RA: The Catholic tradition on the use of nutrition and fluids. *America*, May 2, 1987.
20. Personal communication with Frank Reardon, Esq., counsel to the family of Paul Brophy. I was advised that Mr. Brophy died without pain and with the grace of his family's presence.
21. Koop CE: The right to die. *Human Life Review* II:2, 1976.

Covenant-Making and Medical Ethics

JAMES S. TODD, MD

When I entered the private practice of medicine as a general surgeon in New Jersey in 1964, societal support for the profession and the biomedical effort was at an all-time high. I was conscious of assuming the duties and obligations of an ancient and honored profession. Those duties and obligations, subsumed under the rubric of "medical ethics," were what the medical profession gave to society in exchange for the support and latitude society accorded to our profession. The medical ethics of the 1960s had originated in the enlightenment of the 18th century with its emphasis on science and professionalism, and its break from religious and medical sectarian affiliations. While many medical graduates still took the Hippocratic oath, swearing "by Apollo . . . and all the Gods and Goddesses," it actually was a philosophical allegory for promising to practice with faith in science and new knowledge. Does this mean that we were making a hollow pledge in swearing by Apollo? Not at all. The essence of the Hippocratic ideal is to "follow that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients," and to abstain "from whatever is deleterious and mischievous." That was the ethical component of our promise to society, albeit using the Hippocratic oath as the vehicle. We believed that science would bring forth new treatments infinitely beneficial to patients, and society fully supported us in this belief.

But disturbing signs soon appeared indicating that this paradigm of ethics would not survive the post-1960s cultural earthquake unscathed. An editorial in the July 1955 issue of the *Journal of the Medical Society of New Jersey* pointed to the dearth of articles on medical ethics in the midpoint of the

Dr. Todd is senior deputy executive vice-president of the American Medical Association (AMA). Requests for reprints may be addressed to Dr. Todd, AMA, 535 North Dearborn Street, Chicago, IL 60610.

20th century as compared to the prior "avalanche" of articles on the subject, and concluded, "The general public thinks 'medical ethics' are rules of conduct designed . . . to protect the practitioner rather than the public. Perhaps a rebirth of interest in ethics now is due."

By the 1970s, the technological advances resulting from the postwar biomedical research effort and the widespread questioning of all institutions in society, particularly medicine, demanded a new paradigm of medical ethics. In 1977, I became a member of the New Jersey Committee To Establish Guidelines for the Care of Comatose Patients and the American Medical Association's Ad Hoc Committee To Review the Principles of Medical Ethics. Both committees were separate attempts to update the Hippocratic ideal, one by dealing with the consequences of our new technology so that it would not be "deleterious and mischievous," and the other to readjust the AMA's principles of medical ethics to contemporary times so that society would continue to allow physicians to "follow that method of treatment . . . [they] consider for the benefit of [their patients]."

The Ad Hoc Committee was aware of the public's perception that the ethical code medicine inherited from the enlightenment seemed to be too physician oriented. It recognized that the medical profession no longer is perceived as the sole guardian of the public health. Therefore, the Committee concluded that the profession should have a statement of medical ethics which would be primarily for the benefit and protection of patients, yet clearly would define the relationship of physicians to their colleagues and contemporary society; consistent with all applicable laws; constructively responsive to the physician's relationships with other health professionals; and cognizant of the particular problems of the physician specialist. Presenting the new "Principles of Medical Ethics to the AMA House of Delegates" in July 1980, the Ad Hoc Committee outlined the events in history

and society which made it imperative that medicine and contemporary society be in step:

1. **Societal:** With the licensing and utilization of increasing numbers of limited licensed practitioners, and increasing consumer agitation, it becomes clear that the medical profession no longer is considered the sole guardian of the public health. Some of the profession's traditional responsibilities are being challenged. The issue is not shall the profession share its responsibility—society has clearly decided it should—rather the issue is how can that responsibility be shared without diminishing the quality of health care provided to the public. In a time of constricted resources, the dilemma of responsibility to the individual versus the obligation to society must be addressed. Neither the physician nor the profession can function independently of society and its limitations. The notion of multiple responsibilities for the physician is difficult and, while the patient still assumes prime importance, the needs and constraints of society cannot be ignored.

2. **Professional:** The recent rapid expansion of delivery systems for health care and proliferation of specialties have caused significant disruption in traditional methods of practice and compensation. All of these developments will require continuing accommodation by the profession in order to serve the best interests of patients and society. As technology has advanced, the related social and ethical issues have multiplied far beyond expectation. The capability for the long-term maintenance of the hopelessly ill, genetic alteration, transplantation, and other bioethical issues are going to require new solutions and ongoing evaluation of the appropriateness of the profession's response as new frontiers are passed. Many of the precepts often considered timeless may be ill-suited to the technological explosion of the 20th century.

3. **Legal:** Recent proliferation of laws and regulations applying to the health care system have introduced additional concerns for the profession. Professional freedom to some degree has been curtailed by law, presumably for the common good. Not all such events have been to the liking of the profession, but there are legitimate societal demands and constraints which, if ignored, will be imposed. Such pressures should supply the impetus to review and modify those usages no longer tenable in today's civilization. Modification without justification should be avoided, but acceptance of contemporary reality is essential.

The 1980 "Principles of Medical Ethics" consists

of seven broad, patient-oriented statements. They are medicine's compact with society representing the new paradigm of medical ethics which accommodates technological developments and changes in societal attitudes.

New Jersey is the test site for this new paradigm of medical ethics in terms of publicly dealing with technological dilemmas in medicine through its courts in the Quinlan, Conroy, Jobes, and Baby M cases, and in terms of societal participation on a broad scale, e.g. the Citizens' Committee on Biomedical Ethics. I previously have discussed the new paradigm of covenant-making ethics in this journal.² I still welcome it as enriching our responsibilities by according greater participation to laypeople. I also still believe that we must guard against paralysis of action and accept the societal and medical consequences of remarkable scientific achievements. As our science grows, increasingly difficult choices will be required.

Decision making in the application of ethical principles and moral values governing the allocation of limited resources, and the application of new technology should reflect the views and participation of all segments of society. Physicians frequently are considered by others, and sometimes themselves, as the single segment of society capable of deciding the dilemmas of medical progress. However, this view by the medical profession is grossly inadequate. In matters of social points of view, physicians cut across numerous segments of society. Physicians reflect different religious preferences, geographical influences, and influences of other disciplines. Physicians very often are multidisciplinary in training, experience, and outlook. Physicians, therefore, are uniquely qualified as multidisciplinary to exercise a major, but not sole, role in resolving problems arising in the application of technology in an era of unlimited treatment capabilities and limited resources. Decision making in this area will increasingly determine who shall be treated and the circumstances surrounding that treatment. It is this realization of a need to share societal responsibilities which today presses so closely on physicians.

Although we strive for criteria that are sharply honed to enable fair, humane, and uniform decisions, it must be recognized that, while this is a goal eagerly to be sought, the diversity of our profession and our society makes it unlikely of human achievements. Our covenant becomes patient advocacy within the constraints of reality. We must not abdicate that responsibility. ■

REFERENCES

1. Editorial: Who writes of ethics? *J Med Soc NJ* 7:335-335, 1955.

2. Todd JS: Medical ethics: Where are we? Where are we going? *J Med Soc NJ* 12:816-818, 1981.

A Quest for Balance

ROBERT C. CASSIDY, PhD

In 1983, the following judgment was made in an *amicus curiae* brief filed with the Superior Court of New Jersey on behalf of the New Jersey chapter of the American College of Physicians: "The extent of treatment to be rendered to an acutely ill geriatric patient remains a subject of considerable debate within the medical community. To date, there are no generally accepted standards by which a physician may be guided." The case at hand concerned the medical director of a nursing home who had made his own independent professional judgment about whether to hospitalize severely debilitated patients in his care. When that judgment was challenged, the physician could appeal to general standards of reasonable practice and invoke the tradition of respect for discretionary latitude in physician judgment. However, there were no clear, authoritative guidelines that could direct physicians during the actual decision making, and give objective support to their decisions, if questioned later.

The lack of guidelines for formulating clear, specific agreements about the extent of life-extending therapy also undermines the opportunity by patients

and families to have their values and choices fully regarded. Some professionals procrastinate when it comes to discussing with a patient whether and how he wants to die. In the deluge of immediate problems, the ultimate questions may not receive the careful, reflective consideration they need and deserve. Too often, an acute crisis finally provokes a decision. By then, there may well be too little time for coherent and comprehensive deliberation, so much disability for clear patient expression, and too much pressure on physicians, patients, and families that they cannot make their best judgment of how to serve the human needs of a critically ill person.

With over one and one-quarter million elderly U.S. citizens in nursing homes, the need for clear, comprehensive, and authoritative guidelines for making terminal care decisions is imperative. The "rules of the game" need to be defined. This area of medical decision making, coming under increasing assertions of patient and family autonomy, needs a foundation of recognized principles and processes to secure a mutually respectful partnership in designing plans for "supportive care only."

In order to promote and protect this ideal of responsive and responsible choices about terminal care in nursing homes, the Medical Society of New Jersey, in 1983, charged the Committee on Biomedical Ethics to analyze the problem, to clarify the issues, and "to offer guidance to people involved in making decisions, though not dictate particular choices."

Dr. Cassidy is affiliated with UMDNJ-Robert Wood Johnson Medical School, Department of Family Medicine. Requests for reprints can be addressed to Dr. Cassidy, UMDNJ-Robert Wood Johnson Medical School, One Robert Wood Johnson Place, CN 19, New Brunswick, NJ 08903-0019.



Real medical situations involve real persons. All those real persons—patients, spouses, children, doctors, nurses, and other care providers—are so individual, complex, and diverse as to defy any attempt to dictate categorical answers or rigid procedures. On the other hand, that very diversity and complexity poses a tremendous challenge to the people involved. In order to avoid any inadvertent myopia, parochialism, or autocracy, reflective, comprehensive, and systematic guidelines are needed.

Thus, our first goal was to develop guidelines that would preserve a careful balance between having sufficient flexibility to be responsive to the infinite variety of individual situations, and yet have sufficient specificity to offer practical guidance on definite methods to manage real problems. For example, we strongly urged that discussion should be initiated to develop a plan for terminal care with the patient (if possible) and family "at the earliest possible time." However, we did not prescribe any particular time, such as at admission, as requisite for all cases.

The need for both flexibility and specificity set up a constructive tension that shaped the form of our recommendations.

The problem of authority inherent in our charge created a second challenge, and a second careful balancing of competing, but ultimately complementary, perspectives. "Who should make medical decisions?" is a question that used to have an answer that seemed self-evident. Medical professionals should make medical judgments. The traditional grounds of superior knowledge, discipline, skill, and experience were buttressed by the spirit of professional obligation to take on the awesome burden of making choices about a person's life. Furthermore, since each case is unique, only the immediately present, involved physician could fully know and sensitively decide. Competence united with benevolence, factored by the degree of involvement, authorizes the individual physician "at-the bedside" to decide.

However, such physician autonomy has two pos-

sibly troublesome side effects: first, it may well result in a paternalistic muting of the alternate values and wishes of the patient and family; second, it may overlook the benefits to any one person's judgment of carefully structured consultation with other knowledgeable, concerned persons.

To assure full attention to the patient and family rights to be self-determining about medical care, the Committee developed detailed guidelines for procedures for making supportive care plan decisions. These guidelines covered: who should be involved, how decisions should be made, and how decisions should be documented and communicated. The major goal was to develop procedures that would support both patient and/or family autonomy, and still preserve patient-family-physician unity. These guidelines were intended to provide procedures for partnership.

Regarding the second possibly problematic consequence of medical unilateralism, the Committee agonized over the question of whether and how the physician-directed decisions for "supportive care only" should be reviewed. Two arguments were made against any "outsider" review. It is inappropriate and unnecessary, as less knowledgeable; and it is demeaning and disruptive, as it undermines the physician's authority and threatens the therapeutic benefits of a trusting unity between doctor and patient/family.

However, strong balancing arguments were presented based on both clinical reality and medical history. The clinical reality of the nursing home called for awareness that in addition to the physician, many other skilled, dedicated professionals spend numerous days, months, and even years, working and living with nursing home residents and their families. This professional and personal experience produces invaluable understanding of the basic issues and insight into specific cases. The Committee concluded that such resources should be made available by establishing a review committee to provide collegial consultation and discussion. Such a supportive care plan committee would not supplant the authority of the patient's physician, but it would serve to review the procedural steps, to discuss all options, and to offer its evaluation of the process and outcome.

Historically, this position seemed like a viable and realistic proposal. In 1984, the New Jersey Supreme Court was deliberating the case of Claire Conroy, an elderly nursing home resident whose nephew wanted life-sustaining therapy discontinued. The natural

precedent for action in this nursing home nontreatment case seemed to be the landmark 1976 decision in the matter of Karen Ann Quinlan. In that case, the court was concerned to respect the privacy and sensitivity of families and to preserve the useful sanctity of the private doctor-patient relation. However, the possible abuse of closed-door decisions called for the checks and balances of some form of objective review, especially since these decisions were about life and death. Seeking a compromise between the dangers of unreviewed decisions and the damages of cumbersome, invasive disruptions by outside agencies such as the courts, the court proposed review by an "ethics committee" to confirm the accuracy of the attending physician's prognosis. Such a committee (renamed a prognosis committee in the subsequent guidelines promulgated by the New Jersey attorney general) would serve to diffuse responsibility and screen out inappropriate motivations. The court wrote: "In the real world and in relationship to the momentous decision contemplated, the value of additional views and diverse knowledge is apparent."²

In our deliberations, we anticipated that the procedural precedent of Quinlan would be applied in Conroy to nursing home cases. Clearly, the court would not tolerate decisions to withhold or withdraw life-supportive therapy being made behind closed nursing home doors. Probably, so we believed, the court would propose utilizing a similar review by a committee of nursing home professionals. Concurring with their anticipated recommendation, we promulgated guidelines for a supportive care plan committee to review and evaluate such decisions.

Unfortunately, the court chose a less collegial form of review. Because of a lack of trust in the available nursing home professionals, the court in its 1985 Conroy decision insisted upon a review conducted by the ombudsman for the institutionalized elderly.³ Unfortunately, this is not the place to debate the wisdom or efficacy of that requirement for a more outside and more adversarial review. It remains, however, our belief that the goal of balancing subjective sensitivity and objective accountability are better served by a multidisciplinary committee of nursing home professionals committed to responsive and responsible review of these tragically difficult situations. We also most strongly would reaffirm what was set out at the conclusion of the section of the *Principles of Supportive Care*: "The basic goals shall be full discussion, full understanding, full agreement, full documentation, and full review." ■

REFERENCES

1. Medical Society of New Jersey: Charge to the Committee on Biomedical Ethics, 1983.

2. *In re Quinlan* 70 N.J. 10, 355 A. 2d 647 (1976).

3. *In re Conroy* 98 N.J. 321, 486 A. 2d 1209 (1985).

Committee on Biomedical Ethics

ROBERT L. PICKENS, MD

The Committee on Biomedical Ethics of the Medical Society of New Jersey met for the first time on October 12, 1983. Under the able leadership of the late Dr. Eckstein, the Committee sought to bring ethical analysis of the practice of medicine to the issues confronting physicians and patients. The Committee hoped to clarify the issues and highlight the facts that were relevant for decision making. The goal was to offer guidance to people involved in decision making and not to dictate particular choices. The Committee would attempt to balance the advances of science and technology with the realization that life has a conclusion and the patient has a right to his dignity.

Whereas, institutional ethics committees have served health care practitioners in helping to resolve biomedical ethical problems at individual health care facilities, the Committee on Biomedical Ethics has looked to implement more general guidelines and has taken an active role in supporting the New Jersey Bioethics Commission in its attempt to prepare drafts for legislation. A major concern has been the preservation of the primary physician-patient-family triad as the locus for decision making at the bedside. Throughout all of this, the Committee has emphasized its educational and supportive role and not its role as a decision-making body.

Among its projects, the Committee has formulated a care plan, *Guidelines for Supportive Care Plans for Nursing Home Residents*, in response to a demonstrated need after the Quinlan and Conroy decisions. These guidelines were approved by the Board of Trustees of the Medical Society in 1984.

Dr. Pickens is chairman, MSNJ Committee on Biomedical Ethics. Requests for reprints may be addressed to Dr. Pickens, Medical Arts Building, Suite 100, 281 Witherspoon Street, Princeton, NJ 08540.

In addition, the Committee has been active in support of legislation for living wills or advance directives. Recommendations have been presented to the Governor's Commission on Legal and Ethical Problems in the delivery of Health Care.

Since Dr. Eckstein's death in 1987, the Committee has sought to build on the foundation of his work. It has expanded its membership to include consultants to represent the New Jersey Hospital Association, the Citizens' Committee on Biomedical Ethics, and the legal profession. The Committee has joined with the Citizens' Committee and the New Jersey Hospital Association in the preparation of uniform rules, "Do Not Resuscitate Guidelines," for the state of New Jersey. The Committee has supported actively the New Jersey Bioethics Commission, with its conviction that artificially provided fluids and nutrition be included in the definition of "life-sustaining treatment." The Commission currently is working on rough drafts for a proposed New Jersey Declaration of Death Act and a proposed New Jersey Advance Directives for Health Care Act.

Throughout its deliberations, the Committee has sought input from colleagues as to the kinds of projects that are needed and as to the resources that are available. The Committee welcomes suggestions from all members of the Medical Society of New Jersey for study projects and the development of guidelines. The Committee's primary role as an educational forum can only be implemented by the active support of MSNJ's membership. One of the Committee's ultimate goals is the establishment of a central clearing house for the dissemination of pertinent biomedical ethical information throughout the state of New Jersey. The Committee hopes to sponsor, on a monthly basis, clinically oriented biomedical ethical updates. ■

Medical Education's Ethical Challenge

STANLEY S. BERGEN, JR, MD
CHERYL J. TICE

By the nature of their vocation, good physicians are called upon to practice their art within a framework of high moral sensitivity. For 2,000 years, this sensitivity was guided and directed by the Hippocratic oath, an ethic marked by a unique combination of humanistic concern and practical wisdom admirably suited to physicians' tasks in society. The Hippocratic oath is a physician's pledge to himself, a dedication. It is a broad framework for the ethical practice of medicine rather than a set of rigid rules. The Hippocratic oath provides flexibility of interpretation and adaptation to changing times and conditions, allowing it to retain its validity.

Aristotle and later Galen, though lacking in agreement with all of Hippocratic teachings, accepted his precepts and the guidelines of his oath to reinterpret medical practice and the actions of physicians of their times. Today, physicians still use this oath as guidance for their actions and to reinterpret the ethics of medical practice.

The meaning of the Hippocratic oath changes with the times, social conditions, and medical knowledge,

yet the oath continues to provide a moral standard and ethical framework. The more faithfully a physician fulfills the oath's precepts and expectations, the greater the public respect. Additionally, as part of a greater society and in keeping with the times, physicians' activities and rules of behavior change within a cultural context. By adaptation to the rules that bind us, we further strengthen our profession by acknowledging the influence of the social environment which houses the profession itself.

Until modern times, medical practice and the society in which it existed did not separate moral from technical considerations. In recent times, as the technical means of medicine became more successful, the art of medicine, with its emphasis on the moral component, tended to be overshadowed. Technology itself was not at fault, nor did medical technology arise in response to prior moral concerns. Rather, technology and moral issues in medicine always have been intertwined, inseparable, and mutually reinforcing, while at the same time, providing potential for conflict between them.

"How does the practice of medicine present such an ethical challenge to medical education?" Is medicine a hard science, behavioral science, social science, art, or just a form of humanism? The answers encompass such basic considerations as to how the physician should be educated, what are his funda-

Dr. Bergen is president, UMDNJ and Ms. Tice is his executive assistant. Requests for reprints may be addressed to Dr. Bergen, UMDNJ, 100 Bergen Street, Newark, NJ 07107.



mental obligations, and how he thinks about life itself.

Medicine, however, has its roots in the sciences and the humanities. Physicians actually interpret the knowledge of science to the public and, in addition, utilize the leavening influence of the humanities in their explanation of such. Accordingly, the future of medical practice itself holds challenges that can be met only with a combination of scientific understanding and humanistic awareness. In this regard, the teaching of medical ethics can be considered a two-step process: students are made aware of the ethical problems in medicine and helped to appreciate their own spontaneous reactions, and students learn development of specific professional skills for problem solving in clinical situations.

The issues created by examination of biomedical ethics bring together this practice of medicine, medical education, medical research, government, society, family, self-determination, and individual personal rights. As the world of medical practice has changed dramatically in the last 35 years from a profession which primarily professed caring to one of curing, our capacity to cure has become extensive. Subsequently, our ability to change and extend life is so great that new problems of the quality of life often have supervened and assumed a role in decision making and option choice far beyond what previously had been thought.

The rationale and necessity of ethical training in medical undergraduate and postgraduate education is the promotion of the moral aspect of the practice of medicine. Essentially, this requires the physician to be sensitive to ethical issues and related moral decisions that can be defended to oneself and to others. Although physicians and medical educators have recognized the importance of ethics in medical training, certain trends also have emerged which would impede implementation of these goals.

For instance, information resulting from scientific and technological progress has co-opted much of the curriculum of medical schools and forms the primary content of continuing medical education programs. Increased demands for the physician to make scientific decisions with respect to health care, have overwhelmed the ethical and social issues which have to be considered. Finally, the subtle but pervasive influence by third-party payors that medical care be viewed as a commodity with a definable technical content, rather than as a humane physician-patient relationship, is not measured easily and does not fit easily with a fixed fee schedule. In spite of this emphasis upon economic relations, the public deserves personal attention and thoughtful concern about human values.

Increasing consumer criticism of health care and the emergence of certain ethically difficult cases, have stimulated increased awareness within medical

schools of the need to expose students to the moral dilemmas inherent in medical practice. While many physicians may agree that bedside teaching of ethical issues was the most valuable means of instruction, there remains the doubt that busy clinicians could be depended upon to discuss the moral issues of many patient-management decisions. Even those clinicians who demonstrate a keen awareness of the moral issues raised by everyday medical practice rarely have time during rounds to explore with any depth, the personal and/or medical concerns of their patients.

Disease can affect a country or a political system and endanger people's relations with one another. In such situations, the public is called upon to exercise discipline in its actions and decisions, balancing social values and the public's health against individual rights and the protection of these rights. Under these circumstances, it is useful to recognize and accept the frailty of the human state and view events and decisions as beyond the control of physicians and society. In attempting to adjudicate these differences, the media is quick to criticize, public esteem of medicine diminishes, malpractice actions exacerbate physician-patient relations, and government intervention increases as physicians are accused of failure of self-discipline and self-regulation.

Educators can help develop effective solutions in this complicated, technological, and curing environment. As the dramatic event unfolds, the scientific breakthrough and the sensational cure become a common occurrence. Are changes to be made in the Hippocratic oath that will guide the physician's behavior to maintain the healing, caring role? Often, physicians feel uncomfortable and isolated in this decision-making process. They feel poorly educated and unprepared for such challenges. Even when experience, intuition, and common sense dictate an apparent obvious course of action, the physician may experience anxiety and reluctance to initiate an extraordinary or noncompliant course of treatments.

The ethical training and discussion of ethical issues in the medical schools and on rounds should be viewed as an attempt to improve, update, and adapt to current thought and opinion—to act more in accord with present ideals and circumstance. The remarkable life-sustaining capability of new technology often heightens the need for medical intervention. Patient preference and quality of life intersect with external factors, such as the staggering cost of health care, governmental regulation, and social values which are ever present and must be considered by both patient and physician. Whatever the outcome, either medical intervention or ethical considerations, it reflects the facts, opinions, and circumstances of the times.

Concurrently, it is evident that the practice of medicine is becoming more involved and burdened with the complex emotions and personal problems of patients. In the teaching of medical ethics, one of the most difficult problems is how to strike the right balance between the proper and inevitable concern for the individual and the wider implications of whatever we decide to do. The student must realize that as a physician, his basic ethical consideration is for the welfare of his patient, not the profession. The commitment to the medical care and well being of the individual patient, with the latter's consent, combined with the Hippocratic admonition to do no harm, constitutes powerful and often difficult guidelines to follow.

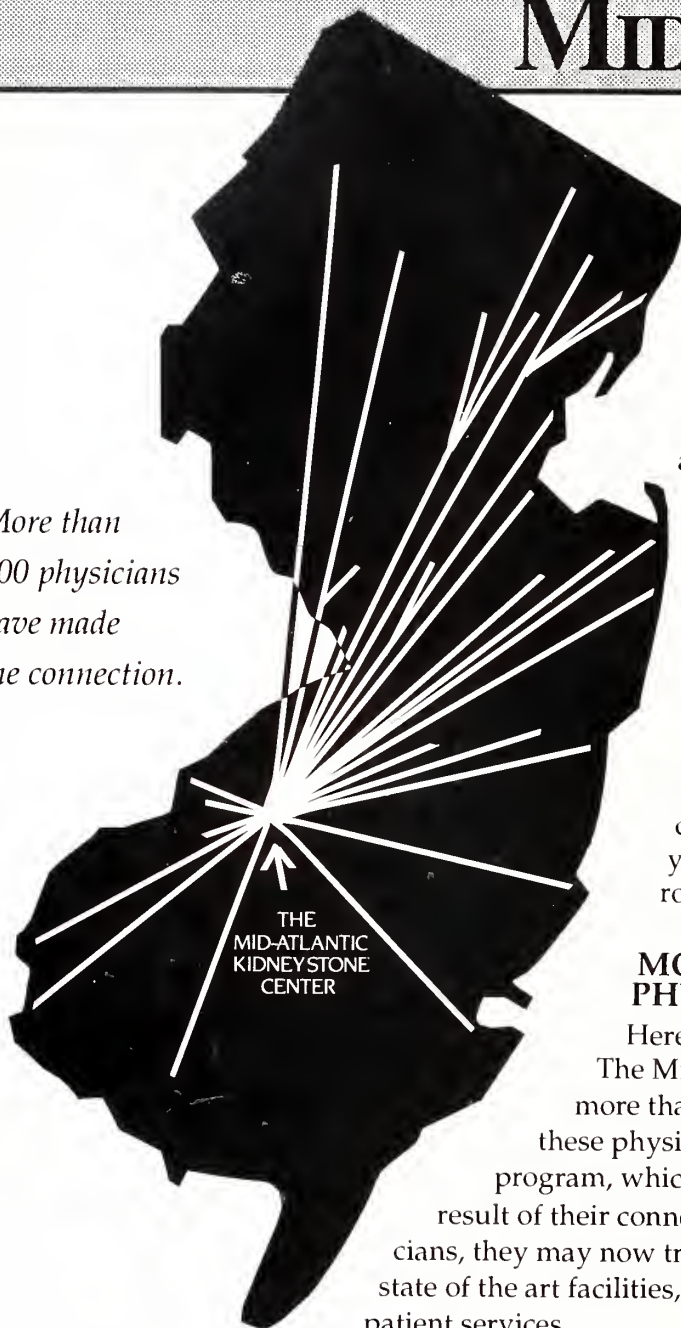
When these guidelines are accepted and implemented, an ethical judgment emerges to assist the patient, family, physician, clergy, lawyers, and nurses in reaching a conclusion and decision concerning a perplexing or unusual problem. There is no single scale to balance; the input of many is utilized for the final determination of a case. It has been the physician's role and responsibility to recommend and pose options of medically indicated treatment, while the patient and family or surrogates retain the right to choose, accept, or refuse—thus weighing the relation of ethical practice to personal autonomy. The goals of medical intervention and ethical challenge must always be directed in order of preference towards restoring health, relief of symptoms or, restoration of function. These decisions, however, are balanced by the patient's desire for and evaluation of the quality of life to be attained within the environment established by community values and medical practice.

CONCLUSION

Dialogue among all sectors of society, open discussion in an honest manner with all facts and knowledge common to all parties, and input encouraged from all segments of the community, provide the basis for improved consideration of ethical issues dealing with biomedical science, the practice of medicine, and the delivery of health care in a cost-conscious society. There is little doubt that the teaching of ethics is part of the teaching of medicine. As the medical school comes to terms with input and interaction from the community, it must avoid the separation of the goals of society from the goals of a healing profession. We must not apportion the contribution to medical practice from the needs of society—physicians must contribute to both in order to fulfill their commitment and serve the patient. We all can contribute to the creation of guidelines and a frame of reference for biomedical ethics and the decision-making process. ■

EXPERIENCE & MID-ATLANTIC

*More than
100 physicians
have made
the connection.*



For physicians throughout New Jersey and from as far away as eastern Pennsylvania, metropolitan New York and Delaware, *Mid-Atlantic* is synonymous with *experience*.

Consider the following: we recently treated our 4,000th patient, a milestone for lithotripter units in the eastern region. Reading between the numbers, we see an unparalleled depth of experience that enables us to deliver the clinical excellence and full-service support you demand.

Additionally, we recently celebrated our third year of operation. Through this experience we have developed a unique sensitivity to your patients, your concerns and the role that we play as a service to both.

MORE THAN 100 STAFF PHYSICIANS AND GROWING

Here's another fact we're proud of: The Mid-Atlantic Kidney Stone Center has more than 100 physicians on staff. Many of these physicians learned lithotripsy through our program, which is now AUA and ALS certified. As a result of their connection to Mid-Atlantic as staff physicians, they may now treat their patients here, enjoying our state of the art facilities, full support staff and comprehensive patient services.

MAKE THE CONNECTION TODAY

Mid-Atlantic's experience is yours for the asking. To find out more about Mid-Atlantic's services and our physician training program, call us at 1-800-53-LITHO or (609) 983-7337.

Managed by
MEDIQ Healthcare Resources, Inc.



**THE MID-ATLANTIC
KIDNEYSTONE CENTER**

A LITHOTRIPTER SERVICE
One Brick Road, Suite 103
Marlton, NJ 08053

The Challenge of Ethics

**T. PATRICK HILL
MARY S. STRONG**

In the late Jacob Bronowski's terms, our civilization is "face to face with its own implications." We have made such dramatic progress harnessing energy, managing productivity, and instantaneously communicating worldwide, that now we can operate on geometric scales, the limits of which are the limits of earth itself. But we are approaching those limits and, as a consequence, asking whether we have a future.

More specifically, ours is a generation that historically has been caught woefully unprepared for the dilemmas caused by the application of technology to medical care. Our public policies, our legislation, and our ethics have been caught off guard. It is, therefore, our responsibility as members of a representative democracy to address these issues in such a way that future generations will benefit from the balance, wisdom, and fairness of our deliberations.

The challenge is to see our way through. And from where we stand, if, to see, you have to wear glasses, you might as well wear rose-colored lenses. This simply is a comment on the reality of the situation we see everywhere around us.

Requests for reprints can be addressed to Ms. Strong, Citizens' Committee on Biomedical Ethics, Inc., 24 Beechwood Road, Summit, NJ 07901.

The reality is that we are finely balanced on the edge of ambiguity, and the proof that we have come this far intact is that we can live positively in the company of this ambiguity. In 1983, when some began to think about a citizens' committee on biomedical ethics, no doubt they were responding to a central ambiguity of contemporary medical practice—the youngest of sciences, promising to humankind with its seemingly miraculous technologies, while threatening the basic values central to our humanity. Propelled by some technological imperative, modern medicine was running the risk of transforming us from patients in an iron lung into prisoners in an iron mask.

The Citizens' Committee came into being on the premise that the only deterrent to medicine's technological imperative might be the intervention of ethics. It was as though we had several fundamental questions to ask. Is the nature of man such that he can cope with the possibilities of medical miracles as he confronts fundamental and agonizing medical problems? Can he hope against hope at the same time as he considers treating or not treating the terminally ill adult, or the imperilled newborn; giving a scarce organ to one person rather than another; experimenting now with today's hopeless case in the deliberate expectation of being able to treat later

tomorrow's hopeful case? May he submit himself to the imperatives of a medical technology capable of so much, or should he, for the sake of the integrity of his moral choices, stick to the free decisions of the heart that seem to offer so little? Can we—patients, doctors, and nurses—pursue the promises of medical technology while we protect the interests of our humanity which endures beyond, and transcends, the most inhumane of diseases?

For the past year now, members of the Citizens' Committee have posed that fundamental question to their fellow citizens from every walk of life in every part of the state in 130 community and professional meetings. The unmistakable implications are that our fellow citizens welcome the question, however chastening and taxing it is. More important, the signs are that they have an instinctive sense for the source of a generally acceptable answer, rather than a cut-and-dried-answer.

In July 1988, the Citizens' Committee released its final report on a statewide survey of public opinion on a range of medical-ethical issues, including responsibility for protecting and maintaining life, responsibility for cost and payment for medical care, selecting recipients of scarce medical care, and the refusal of medical care.

The general conclusion is that the survey bears out the generalization that Americans are pragmatists, not ideologues.

The common theme expressed throughout the data is that while arguments about issues in biomedical ethics often tend to be dominated by those with strongly held feelings, often representing extreme, polarized positions, the majority of the 1,251 respondents holds more finely nuanced and central views.

For example, respondents overwhelmingly feel that adults, regardless of age or physical disability, bear the primary responsibility for protecting and maintaining their own lives. They also feel that while neither doctors nor society (state or federal government) bear the primary responsibility, they consider doctors to be far more likely than society as a whole to have some responsibility.

A similar gravitation to the center and avoidance of extremes, as well as a corresponding view on nuanced judgment are found in responses to such questions as: Who should pay for medical treatment? Who should enjoy preference for that care?

Information of this kind suggests a number of things. Members of the general public represented in our survey are not looking for panaceas for the critical medical-ethical issues facing them. They would prefer broad-stroked guidelines by means of which specific and individual choices can be made without fear of condemnation or obstruction from

groups or individuals who might make different choices in similar circumstances. For example, in one forum at Barringer High School in Newark, there was radical disagreement among the students about how to deal with an imperilled newborn, along with a daunting realization that no reasonable solution would be possible unless it included respect for people whose views differ from other people's views.

This, in turn, suggests the need to shape a moral consensus within society, something which will require an unusual level of educational work. Here, the Citizens' Committee has initiated two approaches. The first is designed to establish curricular programs in biomedical ethics in our schools and colleges. To this end, we already have set up an education subcommittee and established formal liaisons with the New Jersey State Department of Higher Education and the New Jersey State Department of Education and the family life curriculum project at Rutgers University. In addition, other professional groups have approached us to assist in developing educational programs for their membership. Also, as a result of holding a 1987 forum at Oak Knoll School in Summit, that school provides a program on biomedical ethics as part of its regular curriculum. We expect to see developments of this kind increase.

Second, by deliberately adopting an issues-neutral position, the Citizens' Committee has been able to provide educational forums for schools, colleges, hospitals, professional and civic groups, and the general public, which exclude no opinion, and make possible the scrutiny of all. It is, we feel, in the cut and thrust of such public discussion that we can, as a society, avoid authoritarian ethics and forge a pluralism that indeed is ethical. But to be tolerant for the sake of such a pluralism does not mean ascribing equal ethical value to everyone's individual ethic, since to do that threatens to ascribe no ethical value to any of them. On the contrary, to be tolerant of another's differences, assumes that we can draw the distinction between tolerance and indifference so that our choices and other's choices are born of principle and not expediency; so that we can ensure a rarely realized paradox, reasonable individual autonomy, and reasonable social harmony; so that for once the pragmatic also is the ideal. This, surely, is the best of all possible worlds.

As Lewis Thomas said in *The Youngest Science*, "With luck we may come through. The luck will have to be incalculable, and unbelievably on our side over the next few decades. The good thought I have about this is that we are, to begin with, the most improbable of all the earth's creatures, and maybe it is not beyond hope that we are also endowed with improbable luck." As we said, if you wear glasses, you might as well use rose-colored lenses. ■

Nursing Homes and Ethics Committees

ANNE R. SOMERS

New Jersey is groping for a viable solution to an extremely difficult problem—terminal illness in an environment marked by limitless technology but limited resources, and a plethora of litigation but a dearth of alternative procedures for responsible decision making. Over the past decade, the state has made significant progress in defining both procedures and standards with respect to hospital patients and hospital institutional ethics committees (IECs).¹⁻⁵ Now, it is beginning to come to grips with equally difficult problems arising out of the nursing home setting.⁶⁻¹¹

A full-scale study of IECs and nursing homes is planned by the New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care (Bioethics Commission), with Michael Nevins, MD, as chairman of a special Task Force. In this paper I will summarize recent relevant legal developments, and the views of a representative group of nursing home administrators and public spokesmen on several of the major issues.

LEGAL BACKGROUND: QUINLAN TO JOBES

To what extent does the Quinlan decision—the first to recommend establishment of IECs in hospitals—apply to nursing homes?² Are there significant differences in the legal status, principal functions, and structure of IECs in the two settings? There is

uncertainty on both points. The guidelines issued by the Medical Society of New Jersey, the New Jersey Association of Osteopathic Physicians and Surgeons, and the New Jersey Hospital Association, following Quinlan, reinterpreted the decision in several important respects.³ The term “ethics committee” was changed to “prognosis committee,” based on the court’s statement that “the focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life.”

The locus of such committees was extended to all health care facilities, including nursing homes, and the possibility of regionalized or shared committees was suggested as a practical approach. Committee composition specifically was limited to physicians with the requirement that at least two physicians not be on the staff of the institution in question. Detailed procedural instructions were spelled out, culminating in “a specific written finding as to whether there is no reasonable possibility of the patient’s ever emerging from a comatose condition to a cognitive, sapient state.” The guidelines concluded: “The function and responsibility of the prognosis committee is limited to the application of specialized medical knowledge to a particular case in order to arrive at a determination of concurrence or nonconcurrence with the prognosis of the attending physician. Once that determination has been made and reported, the committee thereby has discharged its responsibility. The attending physician, guided by the Committee’s decision and with the concurrence of the family, may then proceed with the appropriate course of action and, if indicated, shall personally withdraw life-support systems.”

Mrs. Somers is affiliated with UMDNJ-Robert Wood Johnson Medical School. She was assisted by Tim Bricker and Elizabeth Horn. Requests for reprints may be addressed to Mrs. Somers, 31 Scott Lane, Princeton, NJ 08540.



Photo: Karen Fucito

The group that produced these guidelines did so with a full sense of the heavy responsibility—medical, moral, and legal—implicit in the task being assigned to the new committees. However, the prognosis committee, as here described, is much more limited—both in composition and in function—than that envisioned by the Quinlan court. The conflict between these two views has been at least partially resolved in the hospital setting—through frequent coexistence of two separate bodies. While some committees assume both functions, many New Jersey hospitals now have prognosis committees which focus exclusively on individual case review.⁵ Some also have ethics committees which focus primarily on policy setting, staff education, and patient/family counselling.

Aside from the question of resources for such a two-committee solution, the jurisdictional issue in the nursing home setting is even more complicated.¹¹ In a separate development, and in the effort to assure the general rights of all nursing home patients, in 1976, the state legislature enacted a Nursing Home Patients' Bill of Rights (N.J.S.A. 30:13-1-11). The following year, it established an Office of the Ombudsman for the Institutionalized Elderly to protect their "health, safety, welfare, civil, and human rights" (N.J.S.A. 52:27G-1 to 16). In 1983, the ombudsman law was amended to include mandatory reporting of abuse of elderly institutionalized patients (60 years of age or older) by health care workers, and mandatory investigation of all such reports by the ombudsman (N.J.S.A. 52:27G-2). "Abuse" is defined as "the willful infliction of physical pain, injury, or mental anguish; unreasonable confinement; or the willful deprivation of services . . . necessary to maintain a person's physical and

mental health."

The implications of the latter phrase for decisions regarding the termination of treatment are obvious and not yet resolved.

Meanwhile, a third variation on the IEC theme—a Supportive Care Plan and Supportive Care Committee for nursing home residents—was drafted in 1984 by the Biomedical Ethics Committee of the Medical Society of New Jersey and approved by the Board of Trustees the following year.⁶ This document was created in anticipation of a court-recommended Quinlan-type committee review in nursing home cases.

The anticipation proved to be in error. The 1985 Conroy decision, rather than following Quinlan in recommending institutional review, spelled out a detailed requirement for administrative review through the office of the ombudsman.⁷ In justification, this court emphasized the significant differences in patients, doctors, and the "institutional structures of nursing homes and hospitals," including the fact that "few nursing homes have 'ethics' or 'prognosis' committees."

In 1987, however, the court reverted more closely to the Quinlan and "supportive care" approaches. The Jobes case dealt with a young nursing home patient to whom the ombudsman law does not apply.⁹ Although acknowledging some validity in the Conroy court's concerns, the Jobes court stated that "the process of surrogate decision making should be substantially the same regardless of where the patient is located." It continued: "For nonelderly, nonhospitalized patients in a persistent vegetative state . . . the surrogate decision maker who declines life-sustaining treatment must secure statements from at least two independent physicians knowledgeable in neurology that the patient is in a persistent vegetative state and that there is no reasonable possibility that the patient will ever recover to a cognitive, sapient state. If the patient has an attending physician, then that physician likewise must submit such a statement. . . . As long as the guidelines we hereby establish are followed in good faith, no criminal or civil liability will attach to anyone involved. . . . Accordingly, judicial review . . . is not necessary or appropriate."

In a concurring opinion, Justice Pollack emphasized strongly the role of the IEC, especially the nonprognosis functions:⁹ "Such a committee can not only perform an educational and policymaking role, but also act as an advisor to the patient's family and physician. . . . [It] would include a diverse membership drawing upon physicians, clergy, ethicists, nurses, attorneys, and members of the general public."

Pollack then quotes the New Jersey Hospital Association's Ethics Task Force: "An ethics committee enhances, not replaces, the all-important patient/family/physician relationship and affords support for decisions being made within that triad, relying on the courts as a last resort."

The Peter case, decided the same day, involved an elderly nursing home patient who had been in a persistent vegetative state since 1984.¹⁰ A friend, to whom she had given power of attorney, requested removal of her feeding tube. Opposed by the nursing home—which had no IEC—it also was denied by the ombudsman. But the court remanded the case to the ombudsman for reconsideration, saying that the patient had left clear and convincing evidence of a desire not to be sustained by life-supporting treatment in her present condition. About five months later, the ombudsman authorized removal of the tube, and Ms. Peter died.

While the court did not specifically question the ombudsman's jurisdiction, it sent a strong message that patient "advance directives" were to be given decisive weight. Inevitably the question arises whether Ms. Peter, her physician, and the nursing home might have been spared years of uncertainty had an effective IEC been in place at the time.

It also raises the basic question of the appropriateness of assigning such a sensitive and difficult decision to a political appointee. Apparently, most

New Jersey physicians think not. Shortly after the Conroy decision, Dr. Nevins surveyed the membership of the New Jersey Chapter of the American College of Physicians, and found an overwhelming majority opposed to the ombudsman's role as spelled out in this case.⁸ In a letter to me, Dr. Nevins pointed out: "There are no data to permit accurate evaluation of how many cases of withholding treatment have been reviewed. . . . I am convinced that nursing home administrators are intimidated and there have been many inappropriate hospitalizations for terminal care."

Other knowledgeable observers agree. Paul Armstrong, attorney for the Quinlan family, argues that involvement of the ombudsman has "fettered rather than fostered" the rights of the terminally ill elderly nursing home patient.¹¹ Senator John Fay, the first ombudsman, 1977 to 1983, says, "I personally do not feel that the ombudsman is capable of handling the more complex issues, like life and death."¹¹ And Patrick Hill, an officer of the Citizens' Committee on Biomedical Ethics, concludes, "It would be a cruel irony indeed that found the institutionalized elderly at the mercy of the very office set up to be their advocate."¹¹

In the effort to promote an equitable solution to the growing jurisdictional conflict, the Bioethics Commission, in its July 1988 working draft on the Proposed New Jersey Advance Directives for Health Care Act, delineated specific circumstances in which no external review of decisions to forego life-sustaining treatment would be required, as well as other circumstances in which review by qualified institutional or regional ethics committees might be acceptable as an alternative to review by the ombudsman's office.^{*12}

A PILOT SURVEY

In the effort to determine responsible public and professional opinion on these and related issues, I conducted a modest pilot survey of New Jersey nursing home administrators and recognized public leaders in September 1987. Through the cooperation of the New Jersey State Department of Health, the New Jersey Bioethics Commission, and the Citizens Committee on Biomedical Ethics, 217 questionnaires were distributed to 100 administrators, all members of the Commission, and the trustees and advisers of the Citizens Committee. The response rate was 38 percent—nearly half of the public spokesmen and one third of the administrators. While part of the relatively low nursing home response was due to the short response period

Table. Functions and composition of New Jersey nursing homes.

Preferred Functions	NHA*	PS*
Establish institutional guidelines	66	84
Review legal implications	63	41
Advise patient/family	59	65
Minimize professional liability	59	27
Educate staff	59	75
Advise nursing staff	53	53
Advise physician	34	57
Review records	34	45
Verify prognosis	22	45
Examine patient	22	20
Recommend treatment	22	10
Preferred Membership	NHA*	PS*
Physician	90	80
Nurse	88	80
Social worker	72	67
Lawyer	72	65
Clergy	59	77
Family member	56	49
Ethicist	28	73
Administrator	22	—
Concerned citizen	—	8

NHA: Nursing home administrator.

PS: Public spokesman.

*All figures are percentages.

*This applies exclusively to patients who have completed an advance directive. At the present writing, the Commission has not yet studied the situation when there is no such directive.

provided, it also is clear that the issue was not a burning priority.

There was no obvious bias among types of institutions. Both skilled nursing facilities (SNFs) and intermediate care facilities (ICFs) were represented and nearly all participated in Medicaid. Nearly three quarters of the homes were for profit; seven were part of chains; six were public; and two were religious. All homes claimed access to clergy as needed. Sizes ranged from less than 60 beds to over 240 beds. The average age of residents was 83. Many neither have family, friends, nor visitors. According to the administrators, the percentage of residents who have no regular visitors varies from 5 to 60 percent. Deaths in 1986 averaged 26 per home—indicating that decisions on terminal care are not isolated events.

Functions and Composition. On these key and closely related issues, the proportions of respondents—nursing home administrators (NHA) and public spokesmen (PS)—favoring specified functions and categories of membership are shown in the Table. There was considerable agreement between the two groups both on the relative value of the functions listed and the most appropriate membership categories. There was general agreement on the importance of advice to nursing staff, patient/family counselling, and establishment of institutional guidelines. There was considerable difference of opinion on the relative importance of advising the physician and verifying the prognosis (ranked higher by the public spokesmen) and on reviewing legal implications and minimizing professional liability (ranked higher by the administrators). In general, the preference for a broad-based committee reflects the preference for a broad set of functions, and vice versa. On this point, Dr. Nevins commented in a letter to me: "The lingering confusion about the respective roles and compositions of 'ethics' versus 'prognosis' committees might be handled in another way. In establishing institutional policy and for educational purposes the IEC model is fine, and should include a spectrum of lay representatives. It's quite another matter when discussing current cases. If for no other than confidentiality purposes, these clinical discussions would best be limited to the nursing home's professional staff. In other words, the composition of the committee relates to its function, and there is room for both kinds of nursing homes just as in hospitals."

Financial Issues. Sixty-three percent of administrators and public spokesmen agreed that committee members should not be paid, unless they had to attend very frequent meetings. There also were suggestions of seeking out volunteers and paying only if none could be identified.

As to payment for ethical consults, the "yeas" clearly outweighed the "nays" in both groups, most conspicuously (and not surprisingly) among the public spokesmen which, as noted, included a number of ethicists, lawyers, and other consultants.

As to who should pay the costs, a third of the administrators thought they should be charged to third parties, but almost as many said they should be absorbed by the institution itself—although the full implications of absorption were not explored. Nearly 60 percent of the public spokesmen thought they should be absorbed.

Legal Issues. The whole question of IECs arises out of such basic issues as professional and institutional liability and the patient's right to self-determination and privacy. Legal issues clearly became central when the New Jersey Supreme Court and the New Jersey Guidelines suggested, in 1976, that institutional review should, in certain cases, replace judicial review as the appropriate forum for physicians, patients, and families. This function goes far beyond an educational or policy-advisory role and inevitably leads to further questions as to evidence, procedures, confidentiality, and immunity—questions which have been further addressed, not always consistently, in subsequent Supreme Court decisions.^{7,9,10}

Opinions on these issues vary as widely as those on philosophy and functions, and obviously are related. To the extent that committees concentrate on educational and policy-setting functions, there is less concern over liability and procedural safeguards. However, the more deeply they are involved in actual case-review and decision making, the greater the need for procedural safeguards—for all the patients involved.

The hope is that the mere presence of such committees will reduce resorting to the courts and the fear of liability and, at the same time, improve the quality of institutional decision making. This is a highly desirable goal. However, it may be utopian in view of the potential conflict of basic values,* the traditional American litigious climate, and the ever-changing technological milieu in which patient care is delivered. What must be avoided, despite the quest for quicker decisions, greater sharing of responsibility, and the value of multidisciplinary consultation, is a situation where no one can be held accountable for actual medical outcomes and where there is no truly impartial court of last resort.

Despite these caveats, there appears to be a

*A recent article in *Modern Maturity* suggests: "With cries of anguish coming from the hearts and pocketbooks of the country, public opinion is beginning to solidify. The real issue: Do individuals have the right to make their own health-care decisions? And the consensus: Yes, it's a matter of choice."¹³

substantial majority view among informed New Jerseyans that well-organized, responsible IECs generally would be beneficial to nursing home patients. Three-fourths of the public spokesmen said they either would "require" (37 percent) or "urge" (35 percent) such a committee. Only 28 percent said "neither." The majority of responding administrators replied yes when asked whether they thought such committees would be helpful to staff, patients, and/or families: helpful to staff—69 percent; helpful to families—50 percent; helpful to patients—59 percent. A few homes already have committees, but the experience thus far appears inconclusive. Some leaders of the nursing home industry indicate strong preference for a regionalized, but not hospital-based approach.

Joseph Fennelly, MD, medical director of a nursing home, member of the Bioethics Commission, and vice-chairman of the Citizens' Committee, expressed the hopes of many professionals as well as public leaders: "Ethics committees rapidly are becoming a dominant vehicle for tempering the consequences of medical technology. We must have at once the vision, the courage, and the humility to so structure these bodies that they democratize and further humanize our unbalanced system."¹⁴

On the negative side, one objection was that the committee might become a political tool and not address the best interests of patients. Other negative views centered around the exact role of the committee, costs, and the difficulty of recruiting competent physicians. However, if it clearly were understood that the committees were advisory only, not forced onto a system already overburdened with bureaucracy, and if a sufficient number of competent physi-

cians and other professionals could be assured with reasonable ways of paying for their services, then most of the respondents to the New Jersey survey could be considered as favoring the noncompulsory establishment of IECs in nursing homes.

It probably would be counterproductive to mandate IECs for the terminally ill without considering other quality-of-care issues. However, it also is probable that the presence of voluntarily established IECs, especially if respected physicians, nurses, and public representatives are involved, could help substantially to protect the rights of terminally ill patients and their families and to ease the inevitable anguish of dying. They also could help the physician not only in proper decision making in individual cases, but in maintaining a central role in the rapidly evolving long-term care field. For all parties—patients, families, health professionals, and nursing homes—they could help to upgrade general patient care, provide closer links between the institutions and their communities, and minimize the need for resorting to outside government bodies, whether judicial or administrative.* ■

*Although this article is focused exclusively on New Jersey, it is useful to compare the results of this one-state 1987 review with a 1985 national survey, published in the *Journal of the American Geriatrics Society*. There are some differences but the basic findings are mutually supportive. Among the national group's conclusions: "Ultimately, some form of continuing education of staff and patients is needed regarding ethical dimensions in medical care of the elderly in nursing homes. Some form of standing committee, if logistically and financially feasible, would be an advantageous means by which education about ethical concepts and analysis can be applied proactively to both the case review and policy formulation activities. . . . Ideally, ethics committees serve to enhance the decision making without usurping the ultimate authority of the patient (and/or his proxy) and the physician to arrive at the eventual decision in difficult cases."¹⁵

REFERENCES

1. UMDNJ-Robert Wood Johnson Medical School: A review of New Jersey's 'right-to-die' cases. *Info Trends: Medicine, Law Ethics* 3:1-4, 1988.
2. *In re Quinlan* 70 N.J. 10, 355 A.2d 647 (1976).
3. New Jersey Attorney General's Office, Board of Medical Examiners, Commissioner of Health: Guidelines for health care facilities to implement procedures concerning the care of comatose noncognitive patients, and declaration of endorsement by state agencies. Trenton, NJ, 1976.
4. McIntyre RL, Buchalter DN: Institutional committees: The New Jersey experience, in Cranford RE, Doudera AE (eds): *Institutional Ethics Committees and Health Care Decision Making*. Ann Arbor, MI, Health Administration Press, 1984.
5. New Jersey Hospital Association, Council on Professional Practice, Ethics Task Force: *Considerations and Recommendations for Institutional Ethics Committees*. Princeton, NJ, 1986.
6. Medical Society of New Jersey, Committee for Biomedical Ethics: Guidelines for supportive care plans for nursing home residents. Lawrenceville, NJ, Board of Trustees, 1985.
7. *In re Conroy* 98 N.J. 321, 486 A.2d 486 (1985).
8. Nevins MA: Big brother at the bedside. *NJ MED* 82:950-952, 1985.
9. *In re Jobs* 108 N.J. 394.
10. *In re Peter* 108 N.J. 365.
11. Hill TP: Ombudsman's office in transition: Advocate or arbitrator? *NJ Reporter* 17:41-46, 1988.
12. State of New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care: Proposed N.J. Advance Directives for Health Care Act. Staff Working Draft. Sect. 8' A, July 1988.
13. Hoopes R: Turning out the light. *Modern Maturity* 31:29-94, 1988.
14. Fennelly JF: Participatory ethics committees: A model for lay and medical collaboration. *J Med Soc NJ* 82:28-30, 1985.
15. Glasser G, Zweibel NR, Cassel CK: The ethics committee in the nursing home: Results of a national survey. *J Am Geriatr Soc* 36:150-156, 1988.

Communication and Altered Perceptions

KOPEL BURK, MD

During the first four days of my encounter with Guillain-Barré syndrome, paralysis developed rapidly as numbness and tingling announced new areas of involvement. I was overwhelmed with anxiety, and certain that the rapidly developing paralysis would affect my breathing and I would end up on a respirator.

By the fifth day of my illness, the respirator was a grim reality. I now faced the problem all people on respirators have to face: How does one communicate and what does one communicate about? The first task in communication was obvious—how to get the nurse's attention.

I soon devised my method. When my children were small, I entertained them by making all sorts of noises with my mouth. On the intensive care unit, I chose my loudest sound, the sound of the clapping of a horse's hoofs on cobblestone. I made the sound by drawing my tongue suddenly from the roof of my mouth just behind my upper front teeth. Breaking the vacuum produced the sound, and opening up my mouth amplified that noise. My signal could be heard throughout the four-bed unit and into the hallway outside. Whenever I started my "clapping," I got a quick response from a nurse, "I'll be right there, Dr. Burk."

No one in the intensive care unit was good at reading my lips, so I needed a better method of communication.

An alphabet board was crudely drawn up—four lines containing five or six letters on a line. I was on a roto rest table that rotated continuously from side to side. The board was held above my face and an attempt was made to keep it in front of my eyes. Laboriously, the communication began—like charades—"First word, first letter. Is it in line #1 or #2, or #3 or #4?" I would nod at the appropriate line. "Is it A, B, C, or D?" and I would nod for the letter.

Requests for reprints may be addressed to Dr. Burk, 116 Millburn Avenue, Millburn, NJ 07041.

"First word, second letter. Is it in line #1 or #2? And, so it went.

This form of talking had great limitations, and was a poor speller. Time was a factor; the doctor did not have all day to stand and watch. The limiting factor, surprisingly, was the endurance of the person holding the chart for the attending. Often, in the middle of a word or phrase, the chart would slowly lower as the resident's arm gave out, and two of the four lines were out of my field of vision. Communication came to an abrupt end. The frustration was instantaneous for all of us; for me because I did not finish my thought, and for those about me because they did not realize the reason for the sudden break in our "conversation." Sometimes they assumed I was tired, or confused, or had changed my mind. After several days of such frustrations, I finally got across my message—"Keep the alphabet board in my field of vision."

With these initial efforts at communication underway, I began working with my daughter, Tina, on a better system: whole words and sentences on a single card. Our system was even more sophisticated, cards that were color coded. Three sentences were on each card. Pink cards were for personal needs: I'm in pain. I need the bed pan. Please move my arms or legs. Please wash my face. Green cards were questions for the doctors: How was my x-ray? How did the lab work come out? Blue cards were general questions for my family: Have you heard from Mark? How is Rachel? What's new in the world?

The top card in each of the color packs was identical. "Please show me the cards. I want to use the pink group, blue group, or green group."

We added to the cards by using the alphabet board to identify new areas to cover. In about four days we had a whole communication system on color-coded cards.

Just as the color-coded communication cards be-

came a reality, I was presented with a more exciting potential for communication—a new electronic device that held out the promise for real “speech.”

The device consisted of two units: a battery operated vibration unit, a wire extension, and plastic end piece that was held in my mouth on my tongue. I had no use of my arms or hands, so both pieces were held for me. When the plastic extension was in place on my tongue, the “operator” pushed and held down the button to generate the vibrating sound that was amplified at my mouth piece. I would then form the words by muscular control of tongue, facial muscles, and lips. I sounded like “E.T.” with a speech impediment. During the initiation into the use of this device, the “clarity” of my pronounced words was distorted further by weakness of the right side of my face and lips.

If I could have held the device I would have been understood more easily. The vibration buzz that allowed the word sounds to be formed could have been shut off at the end of each phrase or sentence. As it was, the buzz was continuous and it was very difficult for the listener to tell when I had completed a thought. Each “thought” usually required several repetitions before the cadence could be recognized and words identified. The few who could decipher the “spoken word” in the midst of the constant buzzing did so laboriously.

Most people never understood me when I used the speech device. My wife and children were the experts in bringing out the meaning of the sounds. My wife could only understand me when my roto table rotated away from the respirator. The sound of the respirator motor was an added distraction that prevented her from isolating and identifying my formed words in the midst of the constant vibrating buzz.

So what happens when you make a joke—especially if one has a habit of laughing at his own jokes? Did someone ask, “How do you laugh on a respirator?” Obviously, one laughs with difficulty. Actually, very few people find anything funny to laugh at while on a respirator.

But since much of what “happens” is internally generated, I often recognized episodes that struck me as funny. What was funny to me then usually was black humor, a bad joke, or a corny pun.

When I tried to make my “funny” comment, it caused something short of pandemonium. Most conversation was intense. The listener worked hard to make sense out of my sounds. Repetition and cadence were critical to understanding anything other than a few single words. When I suddenly broke the cadence to insinuate my humor, the listener was confused with a new set of sounds not related to the ongoing conversation.

My wife especially became upset at not being able

to understand me. She was my 24-hour-a-day ombudsman and never left me before she was certain that I had no problems, distresses, or anxieties that needed caring for before saying goodnight. The jokes could never be understood with that speech device.

After three or four repetitions, I would pause and rest. I would realize my error in throwing such a monkey wrench into my conversation and I would say, “I’m only making a joke.” Such an admission only brought more confusion and anxiety—I had again changed the words and the cadence.

By now I would be exhausted. Once or twice I rolled my eyes in despair, thinking, “How can I be so stupid by trying to be funny under these circumstances?” That eye rolling gesture would only increase my wife’s anxiety, and she would plead with me, “Don’t be impatient. I can’t understand you, but I will stay here all night until I do.” I would be filled with guilt to have caused her so much distress.

It has been two and a half years since my illness. The 19 days on the respirator seem like a bad dream. The tracheostomy scar assures me of the reality. The experience has been sensitizing to say the least. Whenever I make rounds on the intensive care unit, I usually stop for a moment to watch the patients on respirators. Some of the patients are comatose. Others are awake, but seem confused and restless. An occasional patient, however, is alert and oriented.

I look to see if there has been an attempt to make communication possible for this alert patient—the electronic board, the color-coded cards, or the Cooper-Rand speech device. If I find anything at all, it usually is a crudely drawn up alphabet chart. It is almost as if everyone is required to reinvent the wheel. When I ask about the use of the more sophisticated aids to help this patient communicate, I am told that the patient will be weaned from the respirator in a day or so. This answer suggests that in the priority list of acute medical care needs, communication is not at the top. For the short-term ventilator patient, they might be correct. But anyone involved in the care of a long-term respirator patient or patients with a permanent speech defect should learn about the wide range of assistance in communication available in all hospitals.

Having been chairman of the Bioethics Committee of Overlook Hospital, I am committed to the concept that competent patients should be involved in making decisions regarding their medical care. Such a dialogue requires input from physician and patient. When the patient is on a ventilator, that presents a challenge. Yet, I have been surprised to find that some patients on respirators are more successful at the art of communicating than are their physicians. ■

THE PLANNING GROUP

*A Consulting Firm For
Private Practice*

PHYSICIANS

- MARKETING
- ADVERTISING
- PUBLIC RELATIONS
- BUSINESS DEVELOPMENT AND PLANNING

How To • Set Up A Medical Practice
• Take In Partners
• Market Your Practice
• Get Referrals
• Write A Business Plan
• Improve Office Efficiency
• Computerize Your Office
• Increase Revenues

FREE CONSULTATION

(201) 741-1568

YOCON[®]

YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

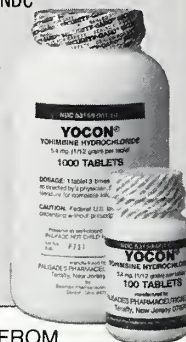
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE EXCLUSIVELY FROM
**PALISADES
 PHARMACEUTICALS, INC.**
 219 County Road
 Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

Ethics in High School

**D. MARLENE CARUSO, RN, MSED
HEATHER MARIE SMITH**

When, as individuals, should we start thinking about issues of medical ethics: When a beloved grandparent's death is postponed by modern technology? When a neighborhood child waits in desperate need for an organ transplant? When a friend contemplates abortion? When a relative worries that his job may be threatened by the results of genetic screening?

Well-publicized dilemmas in medical ethics—Baby Doe, Baby Faye, and Baby M—have underscored the importance of two matters: the need for public discussion and debate on the issues, and the similar need for each of us to examine closely our values, our feelings about life and death, and our notions of what it means to be human. These matters can be effectively explored during high school.

Can today's high school students take a position on a controversial issue and effectively debate their premise? Have high school students learned how to critically analyze the speeches, essays, and actions of others? Can they make responsible decisions through evaluation and thought on issues that confront our society? Secondary school education emphasizes the ability to memorize or restate, more than the ability to form independent, informed conclusions.

The study of bioethics in high schools can help students develop critical thinking skills. The varied issues require students to weigh compassion and legality, common interest, individual rights, their own values, and the values of others. The interdisciplinary nature of bioethics requires students to con-

Requests for reprints may be addressed to Mrs. Caruso, Freehold High School, Robertsville Road, Freehold, NJ 07728.

sider many contributing factors—morality, religion, law, science, economics, history, and social custom—and nearly every young person can find an aspect of the issues of particular interest. The controversy and immediacy of most bioethical issues are attractions for students. They can read in the daily newspaper about an effort to institute mandatory AIDS testing, or view a story about an artificial heart recipient on the evening news.

While bioethics may serve as a means to an end, the study of this topic in high school serves other purposes as well. Debate and discussion on the issues promote debate in the greater population: a first step toward resolving the issues. Unfortunately, it usually is only after we are involved in an issue of bioethics that we raise these questions. Early introduction to issues such as the care of severely deformed infants, active and passive euthanasia, and surrogate motherhood prompts young people to clarify values and positions. Such personal questioning is important for teenagers as they reach independence, and will aid students when they make judgments and decisions of ethical importance on their own. Thorough discussion of the roles morality, ethics, and compassion play in medicine particularly is important for high school students who consider a career in the health professions.

Because of these considerations, a bioethics forum, produced by a student committee of the Medical Sciences Learning Center, was held at Freehold High School. To understand the evolution of this forum, it is necessary to briefly describe the Medical Sciences Learning Center Program. The Center is one of four specialized learning centers in the district offering a comprehensive four-year pro-

gram of math, science, and humanities, for high-achieving, self-motivated students interested in the medical and natural sciences. The program enables students to develop research and process skills which will serve as excellent preparation for further training in any of the numerous careers in the health sciences.

The idea for the bioethics forum, originated by the director, was a logical extension of the curriculum of the Medical Sciences Learning Center. Ethical awareness is an essential characteristic for any systematic, decision-making profession, especially medicine.

The forum was the culmination of a year of planning. A student committee representing all four grade levels was assembled, with the director of the Medical Sciences Learning Center. The selection of a topic proved a difficult task, and after five months of research, debate, and voting, the topic selected was the implications of the success of organ transplant technology.

Several objectives were created when we selected a topic for our forum, entitled, "Organ Donations: The Procurement and Allocation of a Scarce Resource." We wished to develop awareness in the community, through our audience, of the ongoing and increasing need for donor organs. We also wanted to inform the audience of the current status of transplant technology. We hoped to discuss the ethical and legal issues raised by organ donation and transplantation; examine the current system of procurement and suggest how that system can be improved; and determine if our society can ethically allocate a scarce medical resource and, if so, in what manner.

With the essential aid of the Citizens' Committee on Biomedical Ethics, Inc., our committee assembled a panel representing nearly every aspect of our selected topic. Our audience of approximately 150 people consisted of students and faculty members from the Medical Sciences Learning Center, Freehold High School, and other district schools; administrators and members of the district's Board of Education; parents; representatives from local hospitals and service organizations; and representatives from local press organizations. The audience was provided with an information packet prior to the forum containing articles from various sources, providing background information for the morning's discussions. We aimed to emphasize interaction between the panelists and students; the format of our forum was informal. The morning's discussions, led by a student moderator, were divided into two sections: procurement of organ donations and allocation of organ donations.

In an effort to "force" the audience to grapple with

the issue of allocation of organ donations, we divided the audience into small discussion groups to resolve a problem. The small groups were provided with hypothetical descriptions of four patients, all in need of a heart transplant. The hypothetical patients differed widely in their economic, social, and ethnic backgrounds, as well as, in their degree of need. The small groups were told that one heart donation was available, and they were charged with the task of deciding which patient would receive the donated heart.

The reports from each group provided interesting lines of reasoning and prompted lively commentary by the panel. The students, who comprised the majority in the audience, had been forced to make very tough decisions and the experience, though only hypothetical, resulted in some vigorous debate in the small groups over how to go about determining which patient would receive the precious donation. Should the selection be based on ability to pay for the transplant? Should patient age enter the decision? Should a foreign citizen be given the same consideration as a native citizen? What method of selection is most ethical? Who should do the selecting?

The students had to examine what decision was most ethical, equitable, and feasible. Many students, sure of their decisions when the small group segment ended, were not so certain of their decisions when the panelists offered their thoughts. The comments of those individuals gave them reason to re-evaluate what they held as important or judged as ethical.

Response to our forum was extremely positive and student interest in producing successive forums on topics in bioethics is high. The students on the current committee are eager to tackle other issues in bioethics or perhaps sponsor a debate on a timely, controversial issue.

The most encouraging result of our project, however, was the manner in which the students prepared for, and participated in, the forum. The students asked pertinent questions and contributed to the small group discussions in a responsible and valuable manner. Students acted as group facilitators and compiled the research for the audience information packet. As a followup to the forum, students conducted an organ donor card drive. A student committee is working on another forum, in an effort to continue to expose the school community to important biosocial issues.

With this forum, high school students proved that high school is an appropriate time and place to begin discussing some of society's most pressing and controversial issues regarding medicine, technology, and ethics. ■

The Democratic Imperative

PATRICIA MURPHY, RN, PhD

It is difficult to imagine anyone with either the courage or the wisdom to tamper with Abraham Lincoln's definition of how our government ought to operate: "Of the people, by the people, for the people." I suspect most people would agree with that conclusion, but many might not see its connection with bioethical problems.

I heard a noted observer of biomedical ethics on the national scene remark that some time ago people decided these matters were too important to leave solely to medical professionals so "ethicists" came into being. He then went on to remark rather wryly that it now appeared people felt these matters were too important to be decided by anyone but themselves. In fact, that is what the New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care is all about: people making decisions.

The Bioethics Commission, as it is informally known, was established in November 1985 by the New Jersey legislature. The need for such a deliberative body at that time was urgent. This state had become a national leader in addressing the legal and ethical dilemmas in the delivery of health care by modern advances in medicine. Primarily, this had been due to a series of trailblazing decisions by the State Supreme Court and neither the legislative nor the executive branches of the government had been heavily involved. Beginning with the Quinlan decision in 1976,¹ the court ruled on a number of ethical issues brought before it. The Quinlan case recognized the right of a patient, competent or in-

competent, to refuse life-sustaining treatment in appropriate circumstances. This was followed several years later by Conroy² in 1985, and by three related 1987 decisions, *Jobes*,³ *Peter*,⁴ and *Farrell*,⁵ all of which further elaborated both the actual rights and the procedural mechanisms related to refusing life-sustaining treatment. The recent decision in the Baby M case,⁶ currently the leading opinion on the issue of surrogate motherhood, underscores New Jersey's position in another area of bioethics, that of reproductive practices and technologies.

Even as it was carving out new precedents in this most complex and controversial area, the court was saying it would do its duty by continuing to rule, but that these issues more properly belonged with the legislature, the elected representatives of the people of the state. The Commission was formed to implement this objective. Its purpose as stated in the enabling legislation is "to provide a comprehensive and scholarly examination of the impact of advancing technology on health care decisions. The work of this Commission will enable government, professionals in the fields of medicine, allied health care, law, and science, and the citizens of New Jersey and other states to better understand the issues presented, their responsibilities, and the options available to them."

The duties of the Commission include:

"a. Clarify the issues posed by a rapidly developing health and science technology, and highlight the facts that appear to be most relevant for informed decision making by persons as it relates to their care and treatment:

"b. Gather data about how New Jersey and other jurisdictions handle decision making regarding the termination and refusal of care and treatment;

"c. Assess the need for additional programs and services relating to medical decision making;

Dr. Murphy is a member of the New Jersey Bioethics Commission, clinical specialist in bereavement, and clinical assistant professor of surgery at UMDNJ-New Jersey Medical School. Requests for reprints may be addressed to Dr. Murphy, P.O. Box 12, Slootsburg, NY 10974.

"d. Suggest improvements in public policy relating to medical treatment at various levels, not exclusively at the level of state government, and through various means including legislation;

"e. Through its reports, offer guidance for people involved in making decisions, though not dictate particular choices on moral grounds."

The 27 members of the Commission represent the legislative and executive branches of the state government, health care professionals, and the public. Each segment brings a unique perspective to the duties undertaken. Since the Commission is a creation of the legislature whose objective is the recommendation of new law, the representatives of the governmental agencies perform the vital function of keeping the organization linked to those people and procedures that ultimately will be required to accomplish that objective. The political process never is a simple one, particularly when it involves areas such as bioethics which are complex and engender strongly held convictions on the part of many people. A finding or a recommendation which is not workable in the arena of public opinion as represented in the legislature is no recommendation at all and will help no one.

Health care professionals provide insights, expert knowledge of the intricate and difficult technology involved in many of these situations, and vivid testimony on their experiences on the frontline of the life and death decisions they face today. The public representatives bring what may be the most important perspective of all, that of the people about whom bioethical decisions are being made and whose lives will be made longer or shorter, better or worse, by actions the Commission may recommend. These people represent the other end of the crucial human equation that exists between the health care professional and the patient.

The Commission began its existence in March 1986, with a series of widely advertised public hearings, inviting diverse perspectives from the citizens of the state. These hearings took place in Atlantic City, Newark, and Trenton in order to allow geographic access for all. As a matter of policy, we have determined to open all meetings of the Commission and its several task forces to the public, a practice not followed by the only comparable body in another state. Prior to each meeting, the members are provided with extensive background materials taken

from existing literature on the topic of discussion. We have heard testimony from philosophers, nurses, physicians, lawyers, clergy, hospital and nursing home administrators, members of various interest groups and members of the public, including health care consumers. Wherever possible, individuals with first-hand experience are invited to testify.

This approach entails an extensive process of education, study, debate, and deliberation prior to any final decisions. The hearings are many times quite contentious, with differing viewpoints strongly stated and heated discussions. It is safe to say that on more than one occasion, Commission members themselves may not have agreed with the opinions of the witnesses. But agreement is not necessarily the goal of the process nor is consensus in all cases a valid approach to decisions involving life and death and strongly felt convictions about these subjects. Out of the diversity we seek two things:

1) Legislative decisions that will have the maximum benefit for the largest number of people in the state and be acceptable to the majority of those citizens.

2) Suitable exceptions to those decisions to accommodate legitimate moral and religious convictions without, however, imposing those convictions unwillingly on other citizens.

Recommendations currently under consideration concerning the determination of death reflect this sensitivity to legitimate diversity of moral convictions coupled with suitable protection of the individual's decision-making privilege.

The Commission is committed to this collective learning and decision process. Through it, we believe that individuals starting with remarkably diverse perspectives and commitments can learn from one another, refine their understandings and come to a greater appreciation of competing views. Only out of such a process, can we hope to find the middle ground where true decisions of lasting importance and impact can be made.

And that is the essence of the democratic process—a coming together for the purpose of decision making. Since there may be very few things in life more important to people than the quality of their own lives, calling it an imperative of bioethics might even be an understatement.* ■

*Special thanks to Richard Ellis for editorial advice.

REFERENCES

1. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied sub nom., *Garger versus New Jersey*, 429 U.S. 922 (1976).
2. *In re Conroy*, 98 N.J. 321, 486 A.2d 486 #1209 (1985).
3. *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987).

4. *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987).
5. *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987).
6. *In re Baby M*, No A-39, slip op. (N.J. Sup. Ct. Feb 3, 1987).

DOCTORS' NOTEBOOK

**Trustees' Minutes; UMDNJ
Notes; AMNJ Report;
Physicians Seeking
Location in New Jersey**

Trustees' Minutes November 20, 1988

A regular meeting of the Board of Trustees was held on Sunday, November 20, 1988, at the executive offices in Lawrenceville. A detailed report is on file with the secretary of your county society. A summary of significant actions follows:

Report of the President . . .

(1) Resource-Based Relative Value Scales . . . Recommended that specialty organizations wait until the resource-based relative value scale approach has been completely studied before announcing their position on the concept.

(2) Malpractice Surcharge Hearing . . . Noted over 200 physicians attended the hearing at the Department of Insurance on the proposed regulation calling for a 5 percent surcharge on all physician malpractice insurance policies for the next seven years to fund the deficit of the Medical Malpractice Reinsurance Association.

(3) Senior Medical Courtesy Programs . . . Noted MSNJ's position that the determination of the income level for eligibility in the Senior Medical Courtesy Programs is a local prerogative.

Report of Executive Director . . .

(1) MSNJ 1988 Membership . . . Noted total MSNJ membership by county and the Society's AMA membership.

(2) MSNJ Financial Statements . . . Reviewed and approved MSNJ's financial statements for the period ending October 31, 1988.

(3) Legislation . . . Noted that MSNJ is supportive of S-2936 (Licensing Reform) with modifications and noted MSNJ will oppose any movement to place a member of the State Board of Medical Examiners on the disciplinary screening panel or to make the panel the executive committee of the State Board.

(4) Informal Hearings Before the State Board of Medical Examiners (SBME) . . . Noted the necessity for physicians to have legal representation when appearing at an informal hearing before the SBME.

(5) Radiation Protection Commission Education Project . . . Voted unanimously to cooperate with the Radiation Protection Commission in the development of the proposed educational correspondence course. Appointed Dr. Restivo to serve on the ad hoc committee to determine the suitability of the course.

(6) State Board of Medical Examiners (SBME) Percentage Rental Agreement . . . Voted to request the SBME to reconsider their opinion regarding a percentage of revenue arrangement between physicians and physician-investor owned entities.

(7) AMA Analysis of Impact of Resource-Based Relative Value Scale (RBRVS) . . . Received copies of a portion of the AMA worksheet tables regarding the RBRVS.

(8) AMA Litigation . . .

(a) Maximum Allowable Average Charge (MAAC) . . . Was advised by Mr. Maressa that physicians should evaluate their situations regarding MAAC overruns, and stressed the importance of filing an appeal if they feel the position assumed by Prudential is incorrect.

(b) Missouri Supreme Court . . . Noted that under the Missouri living will statute, a feeding tube was not determined to be medical in nature, but considered to be a basic necessity of life and, therefore, could not be removed.

(9) Clinical Laboratory Improvement Act . . . Received copies of the

AMA analysis of the amendments to the Clinical Laboratory Improvement Act; essentially, quality assurance formats and quality controls applied to laboratories also will be in effect in physicians' offices where laboratory testing is performed.

(10) Medically Unnecessary Services Under Medicare . . . Noted Mr. Maressa advised physicians not to allow Prudential decisions to control their judgment, and stressed the importance of filing appeals.

UMDNJ . . . Received the monthly report from Dr. Stanley Bergen, highlighting the following: creation of New Jersey's first National Institute of Health; a partnership between UMDNJ and Roan Ventures to help inventors develop and market their ideas; observations of medical students are permitted on a patient's chart provided the notes are shown to be written by a medical student; and examination of the proposal to establish a Department of Family Medicine.

NJ Hospital Association . . .

(1) More Dollars for Care . . . Received the monthly report noting the Hospital Rate-Setting Commission voted to table action on the Health Commissioner's proposal regarding individual appeal criteria.

(2) Disposal of Medical Waste . . . Voted to ask for a retraction by *NEW JERSEY HEALTH CARE* of the accusations made against physicians in its medical waste article.

(3) Reinsurance Shortfall . . . Voted to ask Mr. Scibetta to discuss NJHA position on the Reinsurance shortfall.

Council on Legislation . . . Approved all the positions recommended by the Council on Legislation, with the exception of the following: A-2524 (AIDS)—referred back to the Task Force on AIDS for clarification and unanimity of opinion with the Council on Legislation; A-3563 (AIDS)—referred back to the Council on Legislation for further reviews; and A-3537 (Contact Lenses)—changed position to disapproved.

Council on Medical Services . . . Referred the following recommendation back to the Council on Medical Services . . .

That Blue Cross-Blue Shield of New Jersey be requested to adopt the following policy on over-65 complementary coverage: That participating physicians in New Jersey Blue Shield will be paid directly by Blue Shield unless they have specifically advised Blue Shield to pay the patient directly.

Council on Public Health . . .

(1) Inspection of Incinerators . . .

Approved the following recommendation:

That the Board of Trustees urge the New Jersey Department of Environmental Protection to review all incinerators, including those at hospitals, to insure their compliance with appropriate air quality standards.

(2) Environmental Health Conference . . . Approved the following recommendation:

That the Academy of Medicine of New Jersey be asked to conduct a conference in conjunction with the Medical Society of New Jersey on topics of current interest in the area of environmental health.

Committee on Biomedical Ethics . . . Approved the following recommendation:

That the Committee on Biomedical Ethics be authorized to work with the Office of the Ombudsman and other state regulatory agencies in order to reach an acceptable solution.

Committee on Young Physicians . . . Adopted the following motion:

That the Committee on Young Physicians be encouraged to present a program of interest to their constituents at some point during the Annual Meeting, with timing to be discussed and negotiated with the Committee on Annual Meeting.

Trustee Screening Committee . . . Approved the following recommendations:

(1) That the Board allow the vacancy in the Fourth Judicial District to remain open, deferring to the regular and customary processes of the Nominating Committee and the House of Delegates.

(2) That the Trustee Screening Committee, having fulfilled its task, be discharged.

New Business . . .

(1) Committee Appointments . . . Unanimously approved the following recommendation:

That the President appoint a committee responsible for the appointment of committee members and chairmen; to be chaired by the president-elect and to include the president and the first vice-president as members.

(2) PRO Scope of Work: 1988-1990 . . . Agreed that copies of pages 6-15 of the PRO Scope of Work document be sent to MSNJ members, with a sample of PRO's form letter and the Society's advice on seeking legal aid; and further, that the Committee on Utilization Review Systems represent the Society at any meetings scheduled with PRO for the purpose of discussing the Scope of Work.

Correspondence . . .

(1) From Philip J. DiBerardino, president of the Bay State Bank . . .

Noted his expression of thanks on behalf of the Triebenbacher family and the Bay State Bank Board of Directors for the contribution to the foundation established in Dr. Triebenbacher's memory.

(2) From Thomas M. Russo, director, Division of Medical Assistance and Health Services, NJ Department of Human Services . . . Noted Mr. Russo's comments that the Senior Courtesy Program is "an important and welcome initiative. MSNJ deserves credit for expanding access to physician services in our state."

Noted his letter concerning MSNJ's resolution regarding mortality and morbidity rates published by the Health Care Financing Administration; he pledged AMA's continuing efforts to deter HCFA's pursuit of its data publication policy.

(3) From James H. Sammons, M.D., executive vice-president, AMA . . . Noted his letter concerning MSNJ's resolution regarding mortality and morbidity rates published by the Health Care Financing Administration; he pledged AMA's continuing efforts to deter HCFA's pursuit of its data publication policy.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D. President

A new \$4.8 million federal contract to determine how pregnant women infected with the AIDS virus transmit that virus to their babies has been awarded to UMDNJ. Our researchers hope the new study will provide information to help them combat the steady increase of children with AIDS. With some 200 cases, New Jersey ranks second in the nation, after New York, in the number of children with the disease.

The five-year project is funded by

the National Institute of Allergy and Infectious Diseases (NIAID), a division of the National Institutes of Health (NIH).

The \$4.8 million will fund research at our Newark-based New Jersey Medical School led by Drs. Edward M. Connor and James Oleske of the Division of Pediatric Allergy, Immunology, and Infectious Diseases, and Dr. Joseph Apuzzio, associate professor of obstetrics and gynecology.

In children, infection with HIV (human immunodeficiency virus)—the acknowledged cause of AIDS—primarily occurs during the perinatal stage. The risk of such transmission from an infected pregnant woman may be as high as 65 percent. The present risk pool of American women of childbearing age who are infected with HIV could result in 10,000 to 20,000 cases of perinatally acquired HIV infection by 1991.

Children born to infected mothers almost always test positive at birth for HIV, but not all remain infected. Estimates of how many infants themselves will become infected vary from 30 to 65 percent. One to two new children now are being diagnosed every week at the nearby Children's Hospital-based pediatric AIDS unit which is run by Drs. Oleske and Connor.

The majority of AIDS victims in New Jersey either are intravenous drug abusers or the heterosexual partners of drug abusers. Participants in the study—"Maternal Factors Influencing Perinatal Transmission of HIV Infection"—are UMDNJ patients who will be mostly from these high-risk groups.

During the study, researchers will seek to determine what effect a mother's health has on the size of the baby and whether it is born prematurely. Infants born to study participants will be tested at intervals to determine if they are infected with the AIDS virus.

UMDNJ-Robert Wood Johnson Medical School's teaching and patient care programs received high marks and a full seven-year accreditation from the Liaison Committee on Medical Education (LCME), the medical school accreditation body.

The gratifying LCME report noted several strengths of our New Brunswick and Piscataway-based medical school, including "outstanding"

teaching of "elective and innovative courses"; "excellent" clinical teaching at Robert Wood Johnson University Hospital and the other teaching affiliates; and "well organized" and "excellent" clinical clerkships at the hospitals, "providing an excellent education to the RWJ medical students."

The accreditation report commended the leadership of former Dean Richard C. Reynolds and the energy he directed to his dual role as dean and senior vice-president for academic affairs. Dr. Reynolds left the University last year to become executive vice-president of the Robert Wood Johnson Foundation.

I would like to add to that the outstanding contribution of Dr. Norman Edelman, who adeptly took up the reins at the medical school with Dr. Reynolds's departure and, quite deservedly, has succeeded him as dean. I thank both of them for their distinguished service and look forward to the continued growth and prosperity of Robert Wood Johnson Medical School.

UMDNJ is on its way to becoming one of the few universities in the nation to achieve a smoke-free environment. The Board of Trustees, voting unanimously to reach the goal by the first day of spring, March 20, accepted the recommendations of a University-wide task force.

"As a leading health sciences institution, we must provide not only excellent health care, teaching, and research, but also set a public example," said Herbert A. Roemmele, board chairman, at last month's meeting. "We strongly concur with the U.S. Surgeon General that smoking is the chief avoidable cause of death in our society and a most significant public health issue today."

The University program will be implemented in graduated phases. The six schools will devise implementation plans at each site, with the help of representative committees composed of smokers and nonsmokers. Employees will be offered smoking cessation and other support programs, and information will be distributed to promote the effort.

AMNJ Report

Benjamin F. Rush, Jr., M.D.
President

The Academy of Medicine of New Jersey has been funded by the New

Jersey State Department of Health for an AIDSLINE which will provide central coordination for a statewide resource referral hotline accessible to all health care AIDS-related education programs with information on AIDS speaker and event availability. AMNJ will work closely with all sponsoring and requesting institutions as well as the NJDOH Division of AIDS Prevention and Control to disseminate a flow of information on AIDS education and educational materials. A monthly newsletter will be published that will include a calendar of events. AIDSLINE will maximize the quality and availability of AIDS-related programs in New Jersey and avoid duplication of efforts and resources. Our AIDS education program manager will be responsible for this program and can be reached at 609/896-0486, 8:30 A.M.-4:30 P.M., Monday

through Friday.

In an effort to attract increased attendance, the Academy's First Wednesday series will move to an evening dinner format. We will continue to cosponsor these events with interested county medical societies and the Citizens' Committee on Biomedical Ethics. The first scheduled session will be held on Wednesday, February 8, 1989, in cooperation with the Mercer County Medical Society. Dr. Ismail Kazem is program chairman.

The Third Annual Governor's Jersey Pride Awards Program culminated on Thursday, January 5, 1989, with the presentation of 12 awards to distinguished New Jerseyans.

The official starting date for the 1989 Internal Medicine Review Course has been set for Wednesday, January 18, 1989. The 19-week course will be held from 4:00 P.M.-

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Category: (Please check one)

☐ Member, MSNJ ☐ Subscriber, NJ Medicine

☐ Other _____

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____

MSNJ ANNUAL MEETING

APRIL 27, 1989—
APRIL 30, 1989

7:00 P.M. on Wednesdays and will end on May 31. The date of April 19 has been omitted from the schedule due to a conflict with the Passover holiday. The course will be held at the Robert Wood Johnson University Hospital in New Brunswick and is cosponsored with the UMDNJ-Robert Wood Johnson Medical School as well as the Hospital.

The course is designed to provide a comprehensive review of contemporary concepts in internal medicine. It is designed for practicing internists and family practitioners. The review also will be useful for residents in preparation for the ABIM exam. Syllabus material will be distributed during the course which, when compiled, will provide an extremely useful reference.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we sug-

gest you make inquiries directly to them.

ANESTHESIOLOGY—Robert C. Mayer, M.D., 32 Pebble Beach Cir., Glendale Heights, IL 60139. Ross University 1985. Board eligible. Group or partnership. Available.

Michael Silverberg, M.D., 2020 Walnut St., Apt. 29K, Philadelphia, PA 19103. Yale 1983. Board eligible. Available July 1989.

FAMILY PRACTICE—Neil S. Skolnik, M.D., 1114 Spruce St., Philadelphia, PA 19107. Emory 1984. Board certified. Group or partnership. Available.

GASTROENTEROLOGY—Curtis Free-land, D.O., 25601 Briar Dr., Oak Park, MI 48237. Des Moines College of Osteopathic Medicine and Surgery 1981. Board eligible. Group or partnership. Available July 1989.

INTERNAL MEDICINE—Diane Barton, M.D., Village of Stoney Run, Apt. 571, Maple Shade, NJ 08052. Temple 1984. Board eligible. Group, partnership, solo. Available July 1989.

Michael T. Burgio, M.D., 54 Jefferson Ave., Pompton Lakes, NJ 07442. St. Georges 1985. Board eligible. Group or partnership. Available July 1989.

Rekha B. Daftary, M.D., 5 Willow Dr., Chester, NJ 07930. Kasturba (India) 1980. Board eligible. Partnership or group. Available.

Leon G. DeMasi, M.D., 24 Whitechapel

Dr., Mt. Laurel, NJ 08054. Temple 1979. Board eligible. Solo. Available.

Chris William Fellin, M.D., 135 Man-ning Terrace Apts., Danville, PA 17821. Hahnemann 1986. Board eligible. Partnership or group. Available July 1989.

Eric B. Hatton, M.D., 800 Rosewood Dr., Clovis, NM 88101. Boston 1982. Board eligible. Group. Available July 1989.

NEUROSURGERY—Hae Dong Jho, M.D., Ph.D., 8327 Elaine Dr., Pittsburgh, PA 15237. Chonnam University 1971. Board eligible. Group, partnership, solo. Available June 1989.

OPHTHALMOLOGY—William Brian Neusidl, M.D., 200 Riverfront Pk., Apt. 13C, Detroit, MI 48226. Temple 1984. Board eligible. Available July 1989.

ORTHOPEDICS—Joseph M. Grant, M.D., Naval Hospital, Box 8, FPO, San Francisco, CA. UMDNJ 1980. Board eligible. Group or partnership. Available July 1989.

PEDIATRICS—Leena D. Parikh, M.D., 1290 Twin Streams Dr., Warminster, PA 18974. B.J. Medical (India) 1972. Board eligible. Group, partnership, solo. Available.

SURGERY—M. Amawi, M.D., 1904 Barham Blvd., Dodge City, KS 67801. Board certified. Group or partnership. Available.

1989 MSNJ Annual Meeting

The Board of Trustees of the Medical Society of New Jersey at its September 18, 1988, meeting, approved the Committee on Annual Meeting recommendation that the 1989 Annual Meeting be held at the Sheraton Meadowlands Hotel in East Rutherford, on Thursday, April 27, through Sunday, April 30, 1989.

The daily schedule follows:

Wednesday, April 26, 1989

3:30 P.M. Board of Trustees' Meeting

Thursday, April 27, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

10:00 A.M. House of Delegates

11:00 A.M. Exhibits Open

1:00 P.M. Program—Topic of Major Interest to Physicians

3:30 P.M. Reference Committee Meetings

Friday, April 28, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

8:30 A.M. Exhibits Open

9:00 A.M. House of Delegates (Election)

12:00 NOON Golden Merit Award Ceremony and Reception

2:30 P.M. Reference Committee Meetings

5:00 P.M. JEMPAC Political Forum

Friday, April 28, 1989

5:45 P.M. JEMPAC Wine and Cheese Reception

6:30 P.M. Middlesex County Medical Society Reception

Saturday, April 29, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

8:30 A.M. Exhibits Open

9:00 A.M. House of Delegates

1:30 P.M. House of Delegates

2:00 P.M. Exhibits Close

6:00 P.M. Inaugural Reception and Dinner

Sunday, April 30, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

8:30 A.M. General Session—Topic of Major Interest to Physicians

1:00 P.M. Board of Trustees' Meeting

CME CALENDAR

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization (indicated in italics) for further information.

ANESTHESIOLOGY

March

- 11- 30th Annual Postgraduate
- 12 Seminar
The Hyatt, Cherry Hill
(*NJ State Society of Anesthesiologists*)

CARDIOLOGY

February

- 3 Myocardial Infarction
- 10 12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(*Bridgeton Hospital*)
- 15 Prehospital Coronary Care
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic
(*AMNJ*)

March

- 15 Post-Infarction
10:30-11:30 A.M.—Christ Hospital, Jersey City
(*Christ Hospital*)

DERMATOLOGY

February

- 14 Dermatological Society of New Jersey
7-10 P.M.—Schering-Plough Corporation, Kenilworth
(*Dermatological Society of New Jersey*)
- 24 Update in Dermatology
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(*Bridgeton Hospital*)

March

- 1 Overview for the Primary Care Physician on Dermatology
7-9 P.M.—The Villa Mattar, Allamuchy
(*Hackettstown Community Hospital*)

14 Dermatological Society of New Jersey

7-10 P.M.—Schering-Plough Corporation, Kenilworth
(*Dermatological Society of New Jersey*)

INFECTIOUS DISEASES

February

- 1 Clinical Management of HIV Infection
9-10 A.M.—Somerset Medical Center, Somerville
(*AMNJ and NJSDOH*)
- 2 Clinical Management of HIV Infection
2:30-3:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(*AMNJ and NJSDOH*)
- 2 Clinical Management of HIV Infection
1:30-2:30 P.M.—Vineland Developmental Center, Vineland
(*AMNJ and NJSDOH*)
- 7 Clinical Management of HIV Infection
11 A.M.-12 noon—Hunterdon Developmental Center, Clinton
(*AMNJ and NJSDOH*)
- 7 Clinical Management of HIV Infection
11 A.M.-12 noon—St. Francis Hospital, Jersey City
(*AMNJ*)
- 8 Counseling and Testing for HIV Infection
11:30 A.M.-12:30 P.M.—Hamilton Hospital, Trenton
(*AMNJ and NJSDOH*)

- 15 AIDS—Medical Malpractice, Criminal Law and Tort Issues
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 24 Clinical Management of HIV Infection
11:30 A.M.-12:30 P.M.—St. Lawrence Rehabilitation Center, Lawrenceville
(*AMNJ*)
- 31 Counseling and Testing for HIV Infection
11:30 A.M.-12:30 P.M.—St. Lawrence Rehabilitation Center, Lawrenceville
(*AMNJ and NJSDOH*)

March

- 1 Counseling and Testing for HIV Infection
9-10 A.M.—Somerset Medical Center, Somerville
(*AMNJ and NJSDOH*)
- 10 Counseling and Testing for HIV Infection
10:45-11:45 A.M.—Greystone Park Psychiatric Hospital, Greystone Park
(*AMNJ and NJSDOH*)

MEDICINE

February

- 1 Geriatrics: Early Office Recognition of Depression
1:30-2:30 P.M.—Essex County

Hospital Center, Cedar Grove
(*AMNJ*)

3- Drugs for the 1990s for All Specialties: An Update on Drug Therapy

Colony Beach Resort, Long Boat Key, Florida
(*American College of Clinical Pharmacology, NJ Section*)

8 AMNJ First Wednesday

Hamilton Hospital, Lawrenceville
(*AMNJ, Mercer County Medical Society, and Citizens' Committee on Biomedical Ethics*)

15 Medical Lecture Series

10:30-11:30 A.M.—Christ Hospital, Jersey City
(*Christ Hospital*)

16 Management of Chronic Air Flow Limitations

12 noon-1 P.M.—Somerset Medical Center, Somerville
(*Somerset Medical Center*)

16 Proper Use of Endoscopy

2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(*AMNJ*)

17 Anorexia and Bulimia

12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(*Bridgeton Hospital*)

22 Proper Use of Endoscopy

10:30-11:30 A.M.—Christ Hospital, Jersey City
(*AMNJ*)

23 Visiting Professor Program

1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(*Saint Barnabas Medical Center*)

March

- 1 Proper Use of Antibiotics
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic
(*AMNJ*)
- 1 Arthritis
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(*AMNJ*)
- 3 Pulmonary Function Testing
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(*Bridgeton Hospital*)
- 8 Winter Dinner Meeting
6:30-9:30 P.M.—Hilton at Short Hills
(*NJ Gastroenterological Society*)
- 9- 37th Annual Meeting
- 12 Bally's Park Place Casino Hotel, Atlantic City
(*NJ Academy of Family Physicians*)
- 10 Sleep Disorders
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(*Bridgeton Hospital*)
- 10 Laser Treatment for Gastrointestinal Bleeding
1-2 P.M.—Woodbine Developmental Center, Woodbine
(*AMNJ*)
- 14 Urinary Incontinence in the Elderly
10-11 A.M.—Green Brook Regional Center, Green Brook
(*AMNJ*)
- 16 Proper Use of Endoscopy

**Personnel
73, 74, 75
Real Estate
74, 75**

**1989 CME CRUISE/CONFERENCES ON
MEDICOLEGAL ISSUES &
RISK MANAGEMENT—**

Caribbean, Mexico, Alaska/Canada, China/Orient, Scandinavia/Russia, Mediterranean, Black Sea, Trans Panama Canal. Approved for 24-28 CME Category I Credits (AMA/PRA) and AAFP prescribed credits. Excellent group rates on finest ships. Prescheduled in compliance with IRS requirements. Information: **International Conferences**, 189 Lodge Ave., Huntington Station, NY 11746. (800) 521-0076 or (516) 549-0869.



and
Bellevue Hospital Center

**22 Week Emergency
Medicine
Board Review
Tuesdays
4:30-7:30 PM**

Designed to enable registrants to review essential material in preparation for the WRITTEN PORTION (Part I) of the EM BOARD CERTIFICATION EXAM. The ACEP Comprehensive Study Guide will be used by faculty as the basis for lecture outline content. Also, arrangements can be made for each registrant to take a TWO-HOUR "1-ON-1 PATIENT MANAGEMENT ENCOUNTER SESSION" that simulates & prepares them for the ORAL PORTION (Part II) of the BOARD EXAM.

Accreditation: 60 AMA Cat. 1 Credit Hrs.

Tuition \$1575

Approved for 60 Hrs. ACEP Credit

Info. available on upcoming courses & tutorial:

#315 EM/Two Track Course - 6/12-16, 1989

#329 EM Board Rev. Course - 10/16-20, 1989

#312 EM Tutorial (by arrangement)

Call or Write: (212) 340-5295/ 24 hour service

NYU Post-Graduate Medical School

550 First Ave., NY, NY 10016

MSNJ 1/89



Jefferson Medical College
Department of Neurology
presents

**BASIC APPROACHES TO COMMON
NEUROLOGICAL DISORDERS**

to be held

February 23-25, 1989

at

The Society Hill Sheraton Hotel
One Dock Street
Philadelphia, Pennsylvania

For further information contact:
The Office of Continuing Medical Education
1025 Walnut Street, Room G3
Philadelphia, PA 19107
(215) 928-6992



Jefferson Medical College
of
Thomas Jefferson University
Department of Neurology
presents

**REFLEX SYMPATHETIC DYSTROPHY:
CURRENT STRATEGIES IN DIAGNOSIS AND TREATMENT**

to be held

March 10, 1989

at

Jefferson Medical College
1025 Walnut Street
Herbut Auditorium
Philadelphia, Pennsylvania

For further information contact:
The Office of Continuing Medical Education
1025 Walnut Street, Room G3
Philadelphia, PA 19107
(215) 928-6992

1:30-2:20 P.M.—Vineland Developmental Center, Vineland (AMNJ)

16 Physical Assessment of the Severely Disabled

10-11 A.M.—Woodbridge Developmental Center, Woodbridge (AMNJ)

17 Pseudomembranous Colitis

12 noon-1 P.M.—Bridgeton Hospital, Bridgeton (Bridgeton Hospital)

23 Visiting Professor Program

1:30-5 P.M.—Saint Barnabas Medical Center, Livingston (Saint Barnabas Medical Center)

24 Management of Abdominal Emergencies

7:30-8:30 A.M.—Atlantic City Medical Center, Atlantic City (AMNJ)

31 Indications for Color Doppler Studies

12 noon-1 P.M.—Bridgeton Hospital, Bridgeton (Bridgeton Hospital)

31 Colitis

9-10 A.M.—St. Francis Medical Center, Trenton (AMNJ)

NEPHROLOGY

February

13 Acute Renal Failure

7-8 P.M.—Wallkill Valley General Hospital, Sussex (AMNJ)

21 Hyponatremia—A Therapeutic Dilemma

6:30-9 P.M.—Overlook Hospital, Summit (Nephrology Society of New Jersey)

March

21 Drug Pharmacokinetics in Renal Failure

6:30-9 P.M.—Overlook Hospital, Summit (Nephrology Society of New Jersey)

ONCOLOGY

February

2 Cancer Research Colloquium

9 3-4 P.M.—New Jersey Medical School, G-506B, Newark (UMDNJ)

24 Breast Cancer

7:30-8:30 A.M.—Atlantic City Medical Center, Atlantic City (AMNJ)

March

2 Cancer Research Colloquium

9 3-4 P.M.—New Jersey Medical School, G-506B, Newark (UMDNJ)

30 Tenth Annual Tumor Board Conference

6-9 P.M.—MSNJ Headquarters, Lawrenceville (Oncology Society of New Jersey)

29 Dinner Meeting

6:30-9:20 P.M.—The Manor, West Orange (AMNJ-Radiation Oncology Section)

ORTHOPEDICS

March

21 Nonoperative Management of Chronic Back Pain

2-3 P.M.—Hunterdon Developmental Center, Clinton (AMNJ)

28 Annual Spring Meeting

Registry Hotel, Scottsdale, Arizona (New Jersey Orthopaedic Society)

PATHOLOGY

March

16 How Can the Clinical Microbiologist Influence the Proper Use of Antimicrobial Agents

6:30 P.M.—Cook College, New Brunswick (American Society for Microbiologists)

PSYCHIATRY

February

1 Case Seminars To Improve

15 Psychotherapeutic Technique
8-10 P.M.—2 West Northfield Road, Livingston (Advanced Psychiatric Study Group)

1 Psychiatry-Anxiety Disorders

10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)

March

1 Case Seminars To Improve

15 Psychotherapeutic Technique
8-10 P.M.—2 West Northfield Road, Livingston (Advanced Psychiatric Study Group)

17 Systemic Lupus Erythematosus

12 noon-1 P.M.—Trenton Psychiatric Hospital, West Trenton (Trenton Psychiatric Hospital)

PULMONARY

February

7 Pulmonary Conferences

14 8-9 A.M.—New Jersey Medical School, H-349, Newark (UMDNJ)

7 Pulmonary Case Conferences

14 8-9 A.M.—University Hospital, New Brunswick (UMDNJ)

March

7 Pulmonary Conferences

14 8-9 A.M.—New Jersey Medical School, H-349, Newark (UMDNJ)

7 Pulmonary Case Conferences

14 8-9 A.M.—University Hospital, New Brunswick (UMDNJ)

RADIOLOGY

February

8 Ultrasound

10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)

16 Radiological Society of New Jersey Meeting

7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston (Radiological Society of NJ and AMNJ)

March

16 Radiological Society of New Jersey Meeting

7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston (Radiological Society of NJ and AMNJ)

SURGERY AND SURGICAL SPECIALTIES

February

7 Surgical Grand Rounds

17 7-9 A.M.—Hackensack Medical Center, Hackensack (Hackensack Medical Center)

14 Microvascular Facial Plastic

Reconstructive Surgery
6:30-10:20 P.M.—Medical Learning Center, Englewood Hospital (Bergen County Society of Otolaryngologists, Head and Neck)

28 Golden Hour in Trauma Surgery

8-10 P.M.—Englewood Club, Englewood (Englewood Surgical Society)

March

7 Surgical Grand Rounds

14 7-9 A.M.—Hackensack Medical Center, Hackensack (Hackensack Medical Center)

28 Medical Conditions Immediately Following Atomic Bombing in Nagasaki

8-10 P.M.—Englewood Club, Englewood (Englewood Surgical Society)

UROLOGY

February

13 Acute Renal Failure

7-8 P.M.—Wallkill Valley General Hospital, Sussex (AMNJ)

22 Urology Meeting

6:30-9:30 P.M.—Holiday Inn, Monroe (Urology Society and Urology Section, AMNJ)

March

8 Urology Rounds

6:20-8:30 P.M.—Robert Wood Johnson Medical School, 108B, New Brunswick (UMDNJ)

16 Drug-Induced Renal Failure

12 noon-1:30 P.M.—Somerset Medical Center, Somerville (Somerset Medical Center)

LETTERS TO THE EDITOR

Deaf Persons and a Hearing Therapist

October 20, 1988

Dear Doctor Slobodien:

In the July 1988 issue, the article, "Case Report: Conjoint Therapy with a Deaf and Mute Couple by a Hearing Therapist," raises serious concerns about the authors' knowledge and competency in the field of deafness.

It is disturbingly evident from the onset that Dr. Bansil and Carmelo Colón have little expertise in working with deaf persons. I find it astonishing that they use the terms "deaf and mute," particularly after referencing the well-respected Dr. Michael Harvey's article which correctly uses the terminology "deaf persons or deaf clients." "Deaf and mute" is a derogatory term; there is no excuse for professionals working with deaf persons to be so grossly pejorative and insensitive.

"An inability to communicate freely due to hearing impairment" is clearly Dr. Bansil's problem, not the clients. Their use of American Sign Language (ASL) allows them a full

range of expression and feelings.

As a licensed psychotherapist and certified interpreter, I must question the efficacy of conducting conjoint therapy without an interpreter, as Dr. Bansil did, "when the interpreter was absent." To use writing for "therapy" is unconscionable, particularly given one client's background of institutionalization until age 12, and the other being raised in a severely deprived and pathological home environment. Numerous studies have validated the difficulties many deaf children have with reading and writing, often achieving only grade levels two to four upon completion of school. Make no mistake; this is a failure of our educational system rather than a reflection on the abilities of deaf children's intellectual capacity. I wonder how effective Dr. Bansil would be in writing with a hearing client in therapy?

Another question arises about the concern Dr. Bansil expresses of his feelings of negative countertransference leaving him "exhausted, powerless, and lacking connectedness" to his deaf clients. I wonder if this is due more to his pejorative feelings than the actual communication modality that should be used when working with deaf clients?

In spite of the negative feelings and attitudes that permeate the article, I think Dr. Bansil is exceedingly perceptive in stating that a major factor contributing to the successful therapy was the support this couple was able to provide each other.

I respectfully recommend that Dr. Bansil, should he continue to offer his services for deaf clients, become knowledgeable in the psychosocial aspects of deafness and deaf culture. I also would hope, as deaf persons become more sophisticated and have more options available for mental health services, that Dr. Bansil's services be judged by quality, not availability.

Fortunately, Dr. Bansil is not the only game in town!

(signed) Mary Ann Klein
A.C.S.W., C.S.C.

November 21, 1988

Dear Doctor Slobodien:

Thank you for forwarding Ms. Mary Ann Klein's letter.

As practitioners with limited experience in working with hearing

impaired clients, we welcome Ms. Klein's comments on our case report, and we look to the expertise of her and other professionals for their constructive contributions in expanding and extending knowledge, awareness, and sensitivity concerning the special factors associated with the provision of services to deaf persons.

We regret any offense created by our use of the terms "deaf and mute," and we are grateful to have been made aware of the pejorative valance associated with that terminology. Our intent surely was not to derogate, and we hope that we have raised some of the complex issues confronting professionals who provide care for deaf individuals.

Ms. Klein also raises a number of other issues which we think deserve attention without further commentary; to wit,

1. While there are evident barriers faced by deaf persons and hearing persons when interacting with one another, it is a mistake to think that deaf culture lacks richness. In fact, American Sign Language provides a range of expression and richness of feeling.

2. Developmental and educational considerations as well as the recognition that the syntax of American Sign Language differs from English often interpose to make reliance on written communication inefficient in interactions with deaf persons.

3. Without making judgments on the source or nature of such feelings, countertransference issues in any therapeutic relationship should not be neglected.

It is clearly evident that professionals should become more knowledgeable and sensitive to the many complex psychosocial aspects of deafness and deaf culture. Our own experience in working with this couple was especially rewarding and resulted in a growing appreciation of the many complex issues of deafness. We have been further stimulated and challenged by Ms. Klein's comments, and we look forward to future constructive exchanges with her and others who can contribute their valuable expertise and guidance in promoting greater awareness and sensitivity toward deaf persons.

(signed) Rakesh K. Bansil, M.D.
Carmelo A. Colón, M.S.S.W., A.C.S.W.

**Cancer: The Outlaw Cell;
Diagnosis and
Management of Renal
Disease and Hypertension;
Immunology and
Immunologic Diseases of
the Lung**

**Cancer: The Outlaw Cell.
Second Edition**

Richard E. LaFond (ed). Washington, D.C., American Chemical Society, 1988. Pp. 274. (\$19.95)

This book is a new and updated edition of a popular book that proved its success in the first edition. Cancer is a topic of general interest because as a disease it is the second most common cause of death. The challenge of understanding cancer is locked inside the cancerous outlaw cell—what Vincent DeVita describes as a black box. Molecular and cellular basic research made it possible to lift the lid off this black box and expose the workings of the cell for all to see.

In 14 structured, logically ordered, clearly written chapters, the contributing authors and the editor succeed in describing and explaining the cancer cell as a unit that differs from the normal cell in its unlimited capacity for division and growth. The mechanisms of cell transformation, the factors that contribute to genetic alteration of the cell to promote tumor formation, the interaction of the transformed cell with the normal host mechanisms, and the influence of chemical, physical, and biological carcinogens that

pave the way masterfully to clinical leads toward the treatment of cancer.

Chemotherapy, radiation therapy, and immunotherapy are discussed in three different chapters with lucid explanation of how the basic characteristics of the cancer cell makes it susceptible and vulnerable to the lethal effect of these modes of treatment.

The book contains up-to-date and sophisticated information on state-of-the-art cancer research, yet the book is written in a clear and simple way by experts on the subjects. It is useful reading for a diverse spectrum of readers; each would derive what he seeks in information on cancer. Thus, the text is recommended to medical and nursing students, science students, scientific writers, science teachers, and the general reader who is curious enough to wish to know more about cancer. The book is rich in illustrated and tabulated explanations. Each chapter is followed by a list of suggested readings; in addition to a thorough subject index, the book includes a useful glossary explaining many of the scientific words in simple language.

Ismail Kazem, M.D.

**Diagnosis and
Management of Renal
Disease and
Hypertension**

Anil K. Mandal, M.D., and J. Charles Jennette, M.D. Philadelphia, PA, Lea & Febiger, 1988. Pp. 540.

The editors have assembled a clear and concise review of nephrology. The text covers all aspects of nephrology including acid base metabolism, electrolytes, clinical nephrology, hypertension dialysis, and transportation. The use of illustrative cases for clarification may be a useful teaching aid for some readers. Tables and illustrations are well done and clarify some complex topics. The section on renal disease in the tropics is unique to this text. The book, however, fails to provide adequate information on a few critically important and contemporary subjects like nephropathy with AIDS. Brenner's hyperfiltration theory of glomerular injury is not covered. The sections on dialysis are somewhat limited.

In summary, the book is a useful

review text for the internist and a supplement for the nephrologist's library. It cannot be considered a complete reference text for the nephrologist.

Seymour Ribot, M.D.

**Immunology and
Immunologic Diseases of
the Lung**

Ronald P. Dantele, M.D. (ed). Chicago, IL, Year Book Medical Publishers, Inc., 1988. Pp. 705.

The text is divided into three sections, beginning with structure and function of the immune system of the lungs. The first chapter gives an overview of the immune system and the rest of the chapters focus on individual aspects of the immunological system and its relationship to the lungs such as antigen handling, the secretory immune system, alveolar macrophages, and morphology.

Section two is dedicated to the pulmonary response to immunologically mediated injury. These form the basic clinical problems seen in clinical practices such as acute and chronic inflammatory/immunological reactions of the lung, immunological mechanisms of pulmonary fibrosis, and granuloma formation.

Section three is dedicated to pulmonary disease states with various diagnostic approaches to granulomatous and interstitial lung diseases, airway diseases, pleural diseases and immune disorders of the lung as they relate to organ transplantation, and the immunosuppressed compromised host such as AIDS.

Overall, the text is an excellent overview of immunologic diseases of the lung; it is quite readable and clinically appropriate. However, if one wanted a text to assist in obtaining more detailed references, one would have to go to Fraser and Pare's four-volume text, *The Diagnosis of Diseases of the Chest*. In addition, as with any text involving the ever-expanding field of immunology, many of the concepts, diagnostic modalities, and treatments still are evolving since the text's publication. I think the text is an excellent supplement for interested practicing physicians in the treatment and care of patients with immunologic disorders involving the lungs.

Leonard Bielory, M.D.

***Drs. Barnes; Carlander;
Duffy; Felden; Fost; Franklin;
Friedland; Greenberg;
Islami; Kley; Levy; Lim; Lynn;
Mockett; Rathmell;
Rosenbaum; Scolamiero;
Shafer; ter-Kuile***

Dr. William C. Barnes, Jr.

William Charles Barnes, Jr., M.D., a member of our Essex County component, died on August 28, 1988. Born in Newark in 1929, Dr. Barnes earned his medical degree from Howard University, Washington, D.C., in 1956. He maintained a urology practice in Montclair for 24 years and established the Metropolitan Comprehensive Health Group in Newark, where he served as chairman. Dr. Barnes was a member of the American Medical Association and was a diplomate of the American Board of Urology. During his career, he was affiliated with The Hospital Center at Orange; Veterans Administration Medical Center, East Orange; Clara Maass Medical Center, Belleville; and Saint James and Presbyterian Hospitals, Newark.

Dr. Oswald Carlander

At the grand age of 90, Oswald Rudolph Carlander, M.D., died on September 24, 1988. Dr. Carlander earned his medical degree from Jefferson Medical College, Philadelphia, in 1925. During his career, he was affiliated with Cooper Hospital, Camden, Zurburg Memorial Hospitals/Riverside Division, and Underwood Memorial Hospital, Woodbury. Dr. Carlander was a member of our Camden County component and of

the American Medical Association, and was a fellow of the American Academy of Orthopaedic Surgeons.

Dr. Joseph F. Duffy

Word has been received of the death of Joseph Francis Duffy, M.D., at the age of 88. A retired member of our Bergen County component, Dr. Duffy received his medical degree from Georgetown Medical School, Washington, D.C., in 1930. Duffy was a member of our Bergen County component, and retired from his general practice in the 1970s. During his career, Dr. Duffy was affiliated with Pascack Valley Hospital and Holy Name Hospital, Teaneck.

Dr. Botho F. Felden

Botho Friedrich-Wilhelm Felden, M.D., a retired member of our Union component died last year. Born in 1890, Dr. Felden earned his medical degree from Berlin Medical School in 1913. He came to the United States in 1924, and received his New Jersey license in 1926. Dr. Felden was a diplomate of the American Board of Dermatology, a fellow of the American Academy of Dermatology, and a member of the American Medical Association.

Dr. William H. Fost

A retired member of our Essex County component, William H. Fost, M.D., died last February at the age of 82. Born in 1906 in Newark, Dr. Fost received his medical degree from the University of Edinburgh, Scotland, in 1931. A pediatrician, Dr. Fost was a diplomate of the American Board of Pediatrics and a fellow of the American Academy of Pediatrics. During his lengthy career, Dr. Fost was affiliated with Clara Maass Medical Center, Belleville, and Children's Hospital, Newark, and was assistant director of the Home for Cardiac Children.

Dr. Charles M. Franklin

Charles Montanye Franklin, M.D., 76, died on August 23, 1988. Dr. Franklin earned his medical degree from the University of Pennsylvania School of Medicine in 1937. In 1939, he began his career at Princeton University until his retirement in 1971; he served as physician for the Princeton University football team, and as an assistant physician and

professor of health and physical education. Dr. Franklin was a member of our Mercer County component, of the American Medical Association, and of the American Psychiatric Association. He was a recipient of the Golden Merit Award from MSNJ for 50 years of service. During World War II, he served as a lieutenant in the Navy medical corps.

Dr. Walter Friedland

A retired member of our Bergen County component, living in Florida, Walter Friedland, M.D., died on September 12, 1988. Born in 1919, Dr. Friedland was graduated from Tulane Medical School, Louisiana, in 1944. During his career, Dr. Friedland was affiliated with Hackensack Medical Center as associate chief of ophthalmology. Dr. Friedland was a diplomate of the American Board of Ophthalmology and a fellow of the American College of Surgeons.

Dr. Philip Greenberg

Retired from the active practice of medicine for ten years, Philip Greenberg, M.D., died on August 9, 1988. Born in 1902 in New York City, Dr. Greenberg earned his medical degree from Tulane University Medical School, Louisiana, in 1932. A family practitioner, Dr. Greenberg was a retired member of our Hudson County component and a member of the American Medical Association. Dr. Greenberg was affiliated with Jersey City hospitals during his career: Fairmount Hospital, Jewish Hospital, Greenville Hospital, and Jersey City Medical Center.

Dr. Abdol H. Islami

The president of our Essex County component, Abdol Hossein Islami, M.D., died on September 18, 1988. Dr. Islami was a surgeon, medical educator, and author from Livingston. Born in 1920, Dr. Islami received his medical degree from Tehran University College of Medicine, Iran, in 1948; that year he emigrated to the United States. During his career, Dr. Islami was affiliated with Clara Maass Medical Center, Belleville; Saint Barnabas Medical Center, Livingston; United Presbyterian Hospital, Newark; and Kessler Institute, West Orange. Dr. Islami was past president of the medical

staff, chairman of the Department of Graduate Medical Education, editor of the journal, and a member of the board of trustees, of the credentials committee, and of the executive committee of Saint Barnabas Medical Center. In 1986, Dr. Islami was presented with the first Lifetime Achievement Award from Saint Barnabas Medical Center for his outstanding contributions. During his career, he was a member of the New Jersey State Board of Medical Examiners, a fellow of the American College of Surgeons and of the International College of Surgeons, a member of the Academy of Medicine of New Jersey and of the American Medical Association, and chairman of the Essex County Chapter of the American Cancer Society. Dr. Islami received much praise for his weekly radio program that was transmitted to Iran, India, Turkey, Israel, and Iraq. He invented a nasogastric intestinal tube that today bears his name. Dr. Islami was an associate clinical professor of surgery at UMDNJ-New Jersey Medical School.

Dr. Edward C. Kley

Word has been received of the death of Edward Charles Kley, M.D., on August 8, 1988. Born in 1916, Dr. Kley was graduated from New York University Medical School in 1941, and received his New Jersey license in 1948. Dr. Kley was associate radiologist at the Veterans Administration Medical Center, East Orange, and at Memorial Hospital, East Orange. A member of our Morris County component and of the American Medical Association, Dr. Kley was a diplomate of the American Board of Radiology.

Dr. Abram Levy

Retired from the active practice of medicine in 1978, Abram Levy, M.D., died on May 6, 1988. Born in 1892 in Philadelphia, Dr. Levy earned his medical degree from the University of Pennsylvania in 1917. An ophthalmologist, Dr. Levy was affiliated with Bound Brook Hospital and New York Eye and Ear Infirmary. Dr. Levy was a retired member of our Somerset County component, a member of the American Medical Association, a fellow of the American Academy of Ophthalmology, and a member of the Academy of Medicine of New Jer-

sey. From 1918 to 1919, Dr. Levy served in the U.S. Medical Corps.

Dr. Anna Lim

Anna Lim, M.D., died on September 16, 1988, at the untimely age of 47. A pediatrician, Dr. Lim was a member of our Somerset County component until 1985. Dr. Lim graduated from the Rangood Medical School, Burma, in 1966. She practiced in Bridgewater for the past 17 years, and was associated with the Plainfield Neighborhood Health Center. Dr. Lim was a member of the Somerset County Visiting Nurses Association, and was affiliated with Muhlenberg Hospital, Plainfield.

Dr. Irving Lynn

Irving Lynn, M.D., a member of our Hudson County component, died on September 8, 1988. Born in 1905 in Jersey City, Dr. Lynn earned his medical degree from the University of Maryland Medical School in 1929. He was a physician in his hometown for 59 years, and was affiliated with St. Francis Medical Center, Jersey City Medical Center, and the Hebrew Home. He was a member of the American Medical Association. In 1979, Dr. Lynn received MSNJ's Golden Merit Award.

Dr. Walter W. Mockett

We have received word of the death of Walter William Mockett, M.D., a retired member of our Bergen County component. Born in 1897, Dr. Mockett was graduated in 1924 from New York University Medical School, and received his New Jersey license in 1933. Dr. Mockett was affiliated with Holy Name Hospital, Teaneck, and was a member of the AMA.

Dr. Thomas K. Rathmell

Thomas Kessinger Rathmell, 84, a member of our Mercer County component, died on September 4, 1988. Born in Pennsylvania, Dr. Rathmell received his medical degree from Jefferson Medical College, Pennsylvania, in 1933. He was director of the Department of Pathology, Mercer Medical Center; clinical associate professor of pathology at Hahnemann Medical Center, Philadelphia; and a consultant for Upjohn Company at King of Prussia. Dr. Rathmell was a diplomate of the

American Board of Pathology, a fellow of the American College of Pathologists, and a member of the American Medical Association.

Dr. Samuel Rosenbaum

Samuel Rosenbaum, M.D., died in July 1984, at the age of 74. Born in West Orange in 1910, Dr. Rosenbaum was graduated from New York Medical College in 1936. A retired member of our Essex County component and a member of the American Medical Association, Dr. Rosenbaum was living in Florida at the time of his death. During his career, Dr. Rosenbaum was affiliated with St. Mary's Hospital, Orange, and Newark Beth Israel Medical Center.

Dr. P.J. Scolamiero

Pasquale Joseph Scolamiero, M.D., retired anesthesiologist, died September 1, 1988, at the age of 78. Dr. Scolamiero received his medical degree from the University of Bologna Medical School, Italy, in 1940. He served an internship and residency at Columbus Hospital, New York. Dr. Scolamiero was a member of our Essex County component and a fellow of the American Geriatric Society. Dr. Scolamiero maintained a practice in Newark for 20 years.

Dr. Albert H. Shafer

A retired member of our Camden County component, Albert Henry Shafer, M.D., died in August 1988, at the age of 88. Dr. Shafer was graduated from Jefferson Medical School, Pennsylvania, in 1925, and received his license to practice in New Jersey in 1926. He was a member of the American Medical Association.

Dr. Reinold W. ter-Kuile

Reinold William ter-Kuile, M.D., died in 1987 after a lengthy career as an ophthalmologist. Born in 1903, Dr. ter-Kuile received his medical degree from University of Rochester School of Medicine, New York, in 1933. Dr. ter-Kuile was affiliated with Hackensack Hospital and Valley Hospital, Ridgewood. He was a diplomate of the American Board of Ophthalmology, a fellow of the American College of Surgeons, a member of the AMA and of our Bergen County component.

AUTHOR INFORMATION

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. The goals are educational and informational. All material published in NEW JERSEY MEDICINE is copyrighted by MSNJ.

CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable

manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statement accompanying material offered to *New Jersey Medicine* must contain the following language and must be signed by all authors:

"In consideration of *New Jersey Medicine* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *New Jersey Medicine*.

SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods used in articles should be identified. Acknowledgements will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 40-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the

source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The **summary** of the article should not exceed 250 words; it should contain only essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

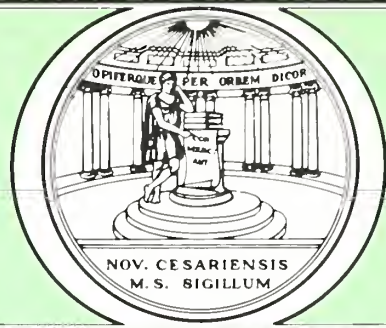
REPRINT ORDERS

Reprints may be ordered after the author is notified that the article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *New Jersey Medicine*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

MEMBERSHIP NEWSLETTER



M
S
N
J

THE MEDICAL SOCIETY OF NEW JERSEY

VOLUME 63

STATE BOARD OF MEDICAL EXAMINERS

Member List

The following persons are the members of the State Board of Medical Examiners. For further information, contact SBME, 28 West State Street, Room 914, Trenton, NJ 08608; 609/292-4843.

Robert B. Ambrose, M.D., Basking Ridge
Sharon Berkowitz, M.D., Brick Town
Mrs. Ruth S. Ballou, Belvidere
Charles Bender, D.C., Middlesex
Floyd J. Donahue, M.D., Westfield
Michael B. Grossman, D.O., Stratford
T. Edward Hollander, Ph.D., Trenton
Frederick Eldridge, Middletown
Sanford Lewis, M.D., Livingston
Edward W. Luka, M.D., Garfield
Frank J. Malta, M.D., Toms River
Joseph McGahn, M.D., Absecon
Nicholas A. Sidoti, Bloomfield
Jeffrey M. Solomon, M.D., Vineland
Harvey Roter, M.D., Livingston
Mary Wysocki, Hackensack

MEDICAL SOCIETY OF NEW JERSEY

Auto Liability Reform Law

A certain percentage of medical malpractice suits are filed in response to bill collection actions by physicians. In some instances, physician bills remain unpaid because they are not covered under the patient's health insurance policies.

Since the inception of no-fault auto insurance, auto accident-related injuries have been fully payable by the injured party's own auto insurance unless the medical bill is disputed by the no-fault carrier as unreasonable or unnecessary.

Under new auto insurance legislation, medical bills for accident-related injuries no longer are fully payable by the insured patient's no-fault carrier.

On January 1, 1989, N.J.S.A. 39:6A-8 became effective. The new law mandates that auto insurance policies issued or renewed on that date and thereafter contain a deductible amount of at least \$250. Insureds may opt for higher deductibles in the amounts of \$500, \$1,000, or \$2,500. In addition to the mandatory minimum deductible of \$250, an insured's no-fault auto insurance company is required to pay only 80 percent of medical bills that fall between the deductible amount and \$5,000. In other words, the injured party

is responsible for payment of the deductible and 20 percent of the medical bills up to \$5,000. Bills in excess of \$5,000 are covered under the personal injury protection portion (PIP) of the insured's no-fault coverage.

Persons covered by Medicare, those who belong to HMOs, and persons with other health insurance are likely to choose deductibles higher than the mandatory \$250. These persons may mistakenly believe that other health insurance will fully pay the deductible amount not payable under their PIP coverage.

In addition, the new law requires that the commissioner of insurance promulgate medical fee schedules on a regional basis for the reimbursement of health care providers of medical services or equipment payable under PIP coverage. The fee schedules are to be based on the type of service provided. The law does not specifically address the issue of whether or not physicians may charge a fee in excess of the schedule set by the commissioner of insurance. It also is unclear whether other health insurance companies will be required to cover the amount of medical bills in excess of the schedule fee.

Physicians who treat patients for auto-related injuries are likely to encounter unpaid bills more frequently under the new legislation. Some injured persons will attempt to obtain payment of losses and expenses through a lawsuit against a driver whom they believe is responsible for causing the accident.

These patients may request that their physicians await payment of the deductible and the 20 percent co-payment portion of their bill until the patient's suit is settled or tried.

The new law, however, limits the injured person's right to sue unless the injured insured has chosen a "zero" threshold option.

Under the new law, the basic tort option exempts a negligent driver from liability unless the injured party has sustained one of the following nine categories of injury: (1) death; (2) dismemberment; (3) significant disfigurement; (4) fracture; (5) loss of a fetus; (6) permanent loss of use of a body organ, member, function or system; (7) permanent consequential limitation of use of a body organ; (8) significant limitation of use of a body function or system; or (9) a medically determined injury or impairment of a nonpermanent nature which prevents the injured person from performing substantially all of the material acts which constitute that person's usual customary daily activities for not less than 90 days during the 180 days

immediately following the occurrence of the injury or impairment.

As a result, patients with unpaid medical bills for auto-related injuries may find that they do not have the legal right to file a claim or suit against the driver whom they believe is responsible for their injuries.

It remains to be seen whether the new auto tort reform law will result in any appreciable increase in bill collection activity by physicians or whether patients who are sued by their physicians for payments of such bills will more frequently resort to counter-claims for medical malpractice when their unpaid bills are not covered by any other insurance. (Submitted by James E. George, M.D., J.D., and Madelyn S. Quattrone, J.D., George & Korin, P.C., Woodbury, New Jersey)

MSNJ PUBLIC RELATIONS

Interstate Public Relations

The following letter was written by Donna Gindes, community relations coordinator, Massachusetts Medical Society:

Thank you so much for filling me in about the exciting public service programming the Medical Society of New Jersey is doing. The materials you sent me were well-executed and eye-catching. They will be very helpful to us in Massachusetts as we assess our marketing strategy. I recently attended a meeting at the Massachusetts Cancer Society and brought along a couple of the posters you sent. They also were a big hit.

MEDICAL SOCIETY OF NEW JERSEY

Patient Scheduling—Potential Liability Trap

MSNJ and the Medical Inter-Insurance Exchange of New Jersey receive numerous complaints that focus on the scheduling practices of physicians. The most common problems are overbooking, lateness, lack of courtesy, and the perception of abruptness. While there can be external reasons for these events, the most frequent cause is a tendency to overbook administrative functions. In today's busy practice, finding time to review procedures often becomes difficult. Periodic review of procedures will help to improve patient care and perceptions while assisting in avoiding litigation.

MSNJ PUBLIC RELATIONS

AAMSE Management Resources Manual

The American Association of Medical Society Executives selected the Medical Society of New Jersey program for inclusion in the AAMSE Management Resources Manual.

The Council on Public Relations is planning on releases for the rest of the fiscal year covering catastrophic health care coverage, alternate health care systems, the accomplishments of medicine, the price of health care cost cutting, and older Americans—a growing force. The media used will include newspapers, magazines (*Time* and *Newsweek*), and television.

The favorable recognition by AAMSE, coupled with satellite television transmission of MSNJ public ser-

vice releases nationally, has reflected favorably on the public relations activity of the Society. We currently are working on the preparation of a television story on the history of New Jersey medicine and the Medical Society of New Jersey. Our efforts in this area will present a true and acceptable image of the continuing efforts of New Jersey physicians to deliver the best possible health care to their patients from the beginning of our country to current times. Suitable demonstrations of the projected promotions will be shown to the Board of Trustees when they are finalized.

MSNJ PUBLIC RELATIONS

New Jersey Network

The following letter was written by Robert G. Ottenhoff, executive director and general manager, New Jersey Network:

On behalf of New Jersey Network (NJN), I just want to extend my utmost appreciation to the Medical Society of New Jersey for their support of NJN's AIDS outreach commitment. As Larry Stuelpnagel explained, this promises to be a major campaign and with the addition of 40 plus radio stations for simulcast, we expect the entire state to be blanketed with this special broadcast.

As you know, good public broadcasting depends on the right blend of politics, and corporate and community support. When public broadcasting works best, it can be the community at its best—a place where government, corporations, and individual citizens work with each other for the common good. Based on our past experience, I can guarantee you that this special week of programming and outreach commitment on the AIDS crisis will be one the Medical Society of New Jersey will be proud to sponsor.

MEDICAL SOCIETY OF NEW JERSEY

PRO Quality Reviews

The following letter was sent to the membership from Palma Formica, M.D., president of MSNJ:

Effective December 1, 1988, a new PRO format for evaluating quality will be in place in New Jersey. For your information a mailing was made to the membership including copies of pages 6-15 of the PRO Scope of Work document, as well as the form letter to be used. (The entire 1988-1990 PRO Scope of Work is available at all hospitals.) Please become familiar with these. You must respond to all notices in order to protect your rights. The Society strongly recommends that if you receive such a notice you immediately consult an attorney familiar with health care law. A prepaid plan is available through the Medical Society of New Jersey for \$190 yearly, but you must be enrolled prior to being aware of a PRO citation.

FINI

"The love in your heart wasn't put there to stay. Love isn't love until you give it away."

CLARK MARTIN*

Medicine's Political Profile; Disciplinary Bill Set for Action

MEDICINE'S POLITICAL PROFILE

With so many important issues hanging in the balance, organized medicine has a huge stake in this year's elections.

This fall, New Jersey citizens will elect a new governor and the entire 80-member Assembly. Thus, we'll move into next year with a brand new administration, and probably a new set of legislative leaders, who will have the power to influence the outcome of issues crucial to the well-being of physicians and their patients:

- Will a surcharge be levied on malpractice insurance premiums to pay off the debt of the defunct Medical Malpractice Reinsurance Association?
- Will mandatory Medicare assignment be forced upon an increasingly hard-pressed physician community?
- Can New Jersey devise an efficient and affordable program to collect and dispose of medical waste?
- Will the legislature pass the structured payments bill, thus giving physicians some much-needed relief from soaring malpractice insurance premiums?

In order for medicine's side of these issues to be heard, we need both an effective message and an audience which is willing to listen and act.

With our lobbying, public relations and a growing corps of physicians who back up our efforts in Trenton, we've no shortage of messengers.

But making sure that a receptive audience is in place to hear the message takes constant replenishment. This is the job of MedAC, our medical action committee.

Not many years ago, medicine's political action profile was a mere speck on the horizon. In the 1981 gubernatorial and legislative elections, for example, we barely were able to raise \$20,000—not enough to help

friendly candidates, much less capture the attention of those who could care less about our issues.

MedAC has made a tremendous difference. In the 1987 Senate and Assembly races, MedAC's contributions of \$196,000 made it the state's third largest PAC. Friends of medicine now know that they can count on MedAC to help at election time. And politicians who once ignored us now seek medicine's guidance and backing.

Along with JEMPAC, our federal political action committee, MedAC this month will begin to evaluate candidates running in the gubernatorial primary elections and gear up for the Assembly races. MedAC, of course, will ask physicians for financial support.

Given the issues, a contribution to MedAC could be the best insurance bargain in town.

DISCIPLINARY BILL SET FOR ACTION

A bill which would revamp the way that the Board of Medical Examiners handles complaints may see committee action in the Senate as early as this month.

Sponsored by Senator Richard J. Codey (D-West Orange), S-2936 would create a Medical Practitioner Review Panel to investigate complaints against physicians, chiropractors, and podiatrists. Its function would be to separate those who investigate from those who ultimately decide guilt or innocence. That authority would remain under the SBME.

The bill was referred to the Senate Committee on Institutions, Health and Welfare, which Codey chairs.

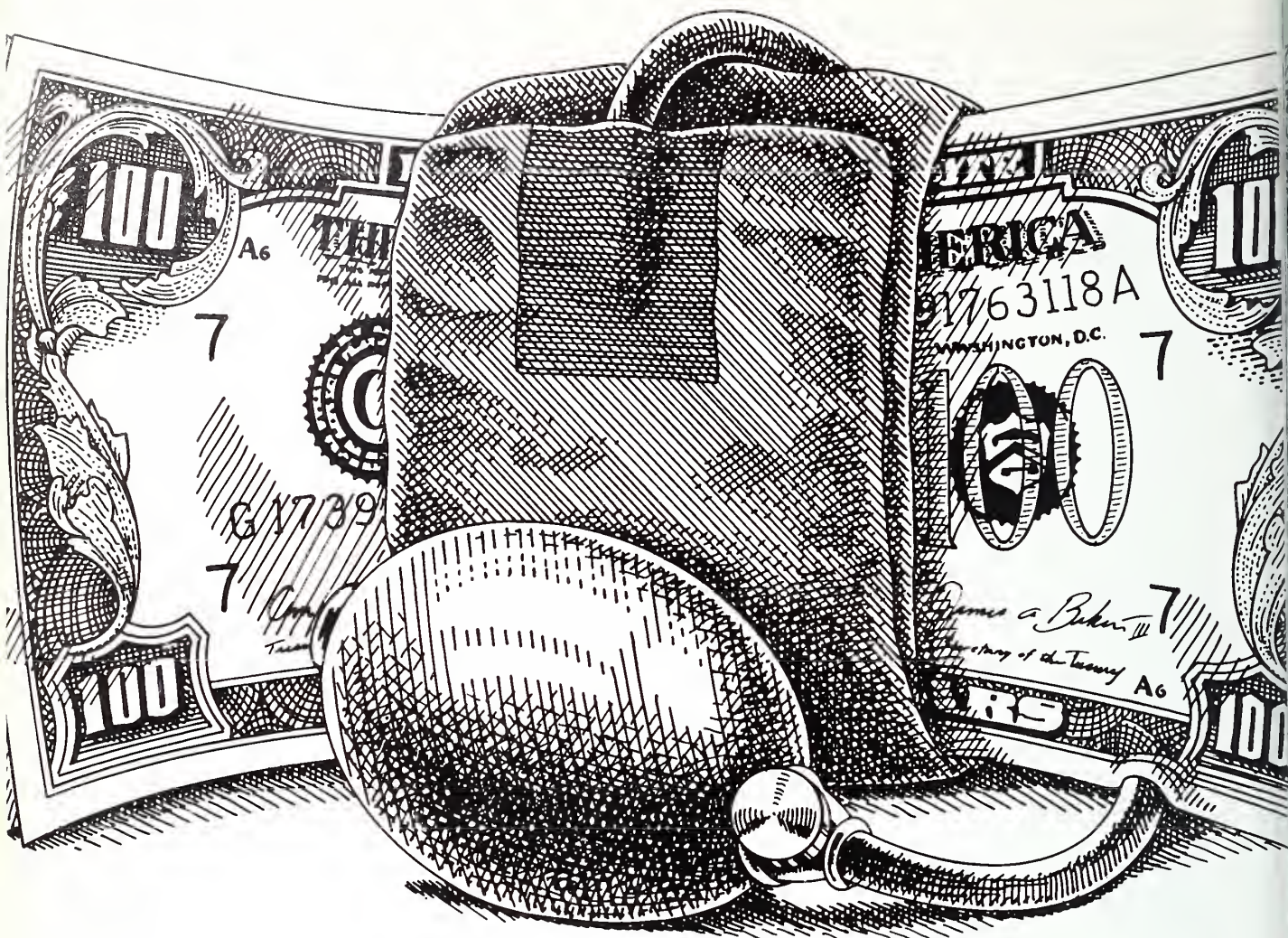
S-2936 results from the State Commission of Investigation's report on Impaired and Incompetent Physicians. Released just over a year ago, the SCI report made lurid headlines and prime-time television news with its charges that hospitals and health care professionals were engaging in a "conspiracy of silence" by not reporting physicians who are incompetent or impaired by alcohol, drug abuse, or a mental or physical disability.

In many key areas, S-2936 reflects a number of recommendations made by former Judge Herbert J. Stern, whom the Society retained as special counsel to respond to the SCI report. However, the bill still needs improvement and the Society is hopeful that Senator Codey and his committee will accept amendments.

Along with creating the Review Panel and expanding the staff of the Board of Medical Examiners, S-2936 would:

- Require hospitals and other facilities to notify the Panel whenever a licensee has a temporary or permanent reduction or suspension of privileges, resigns, is terminated, or takes a leave of absence.
- Requires facilities to notify the Panel if a practitioner is the subject of a complaint or disciplinary proceeding based on misconduct, a physical or mental condition, or the use of drugs or alcohol.
- Requires notification of the Panel of all medical malpractice settlements, judgments, and arbitration awards, regardless of the dollar amount.
- Requires a practitioner to report another whom he believes has demonstrated an impairment, gross incompetence, or unprofessional conduct which would present an imminent danger to patients.

* Mr. Martin is MSNJ's legislative consultant.



INTENSIVE CARE.

Your practice deserves nothing less. And the Medical/Dental Banking Group at Midlantic National Bank/North is uniquely prepared to deliver the kind you need.

Whether you're a third-year resident or long-established in practice, a personalized loan package may be the best prescription for your future. We know the funding needs of new practices, buy-ins, buy-outs and practice expansion may exceed the lending limits of most financing sources. This is why we finance creatively, based on an understanding of medical economics and a repayment plan based on anticipated practice growth rather than fixed schedules.

We speak your language in other areas as well, with practice and personal services such as checking, savings, trust and estate planning, IRAs, custodial accounts, and more.

If you're starting out, start with our free brochure, "The Beginning Physician's Guide to Financing a Practice." Beginner or not, we urge you to call Patrick Robinson, Vice President and Group Manager, toll-free at 1-800-633-0040.

We'd like to make a "house call," and show you how our intensive care can help your practice.

**FOOD FOR THOUGHT
FROM THE HUNGRY BANKERS**

MIDLANTIC
NORTH

MEMBER FDIC

Court Decisions

Young Doctors Serving Poor Go To Mat Over Costly Tail Coverage; Trial Lawyers form Group to Press Acne Drug Birth Defects Suits; Unadopted Person Has Right To Birth Records; Son Sues for Alleged Negligence in Prescribing Tofranil® During Pregnancy

YOUNG DOCTORS SERVING POOR GO TO MAT OVER COSTLY TAIL COVERAGE

Young National Health Services Corps (NHSC) physicians who traded a medical education for promises to serve the poor for up to four years, now are doing battle with their employers over who will pay their tail coverage when they complete their tours of duty. The skirmishes are occurring on unlikely turf—some 1,000 government-funded community clinics where approximately 1,200 physicians are treating the poor.

The young members of the federal physicians corps say their agreements did not include pledges to pay for up to 25 years of malpractice coverage after they leave.

The clinics, sometimes the only source of health care for urban and rural poor, contend they are spending at least \$5 million a year—40 percent more than 5 years ago—to provide tail coverage to physicians who leave the sites. According to one NHSC official, the tail coverage purchases are straining the clinics meager budgets.

"In Jackson, Mississippi," says NHSC deputy director John Hisle, "an obstetrician-gynecologist with 2 years of service delivering children pays \$70,000 for tail coverage which protects the physician for 20 to 25 years in case some patient or parent of a patient sues."

Admittedly, the tail coverage issue is creating tensions between some community clinics and their phy-

sicians. "We end up negotiating between the community health centers and migrant health centers and physicians on who is going to end up paying the tail," Hisle says.

For some, the negotiations turn into outright battles. NHSC physicians serving the poor say they are faced with insurance costs they can ill afford after leaving \$60,000-a-year clinic jobs. "I fought and made a lot of enemies," says 34-year-old internist John Mendelsohn, M.D. He served as an NHSC private practitioner at San Francisco's North of Market Senior Services, where he paid \$600 a year for his first year of malpractice coverage and faced tail coverage costs of over \$10,000. To iron out disagreements over such fringes as malpractice coverage, Dr. Mendelsohn hired a lawyer. (*Medical Liability Monitor*, October 18, 1988)

TRIAL LAWYERS FORM GROUP TO PRESS ACNE DRUG BIRTH DEFECTS SUITS

Some trial lawyers are carving out a new product liability niche with the formation of the Association of Trial Lawyers of America Accutane® Litigation Group. According to the *National Law Journal*, a wave of publicity over a widely used acne medication said to cause birth defects and other maladies could not have come at a better time for this group. Although the drug always has carried warnings that it should not be used by pregnant women, at least 38 suits already have been filed against the manufacturer, Hoffman-LaRoche, Inc. In April 1988, internal Federal Food and Drug Administration (FDA) memos were published that linked Accutane® to birth defects. The FDA apparently received reports of 66 babies born with severe birth defects following use of the acne drug by their mothers, but the FDA said numbers could be much higher—anywhere from 250 to 1,300. (*Medical Liability Monitor*, October 18, 1988)

UNADOPTED PERSON HAS RIGHT TO BIRTH RECORDS

Under the mandatory disclosure provisions of the hospital record statute, an unadopted person has the right to obtain birth records that included the names of patients from the hospital in which he was born, the Florida Supreme Court ruled. The hospital denied the request for birth records of the former foster child. The hospital refused to disclose the birth records on the ground that it was prevented to do so by a statute that barred disclosure of patient records without the consent of the patient, the mother. A trial court directed that a copy of the birth record be released to the individual but ordered that any parents' names be blanked out. The appellate court affirmed but certified the question to the Florida Supreme Court.

The Supreme Court said that an unadopted person had the right to obtain birth records that included the names of the parents from the hospital in which he was born. The court said that there was a sound policy reason for its holding. When a person is adopted, he becomes the lineal descendant of his adoptive parents,

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are the Director of the Department and Director of Special Projects, respectively.

and he no longer may inherit from his natural parents. The individual in question, however, was not legally adopted. He was not the lineal descendant of the couple who reared him. Unless the birth records were disclosed to him, he would never be in a position to claim his rightful inheritance because he would never know the identity of his natural parents. (Printed with permission from *The Citation*, American Medical Association, Volume 57, September 15, 1988)

SON SUES FOR ALLEGED NEGLIGENCE IN PRESCRIBING TOFRANIL® DURING PREGNANCY

An expert who had not yet entered medical school at the time of a physician's alleged malpractice, was qualified to testify regarding the standard of care at that time, a New Jersey appellate court ruled.

The physician treated a patient for obesity and depression. He prescribed Tofranil®, and the patient took the drug from September 1962 through January 1963. The physician performed one pregnancy test, which was reported as negative, in September 1962. He did not repeat the test in spite of the fact that the patient missed her December and January menstrual periods. A son conceived while the patient was taking Tofranil® was born on July 2, 1963, and had numerous birth defects.

The son sued the physician for malpractice. The expert he retained prepared a report concluding that the physician's actions constituted a deviation from acceptable medical standards at the time he was treating the patient. The report stated that the physician did not take adequate steps to assure that the patient was not pregnant when he prescribed the drug, and did not advise her of the dangers of an adverse reaction. The

expert said that the one pregnancy test taken did not absolve the physician from guilt in continuing to prescribe a medication that was teratogenic, and that failing to repeat a pregnancy test was a deviation from accepted standards. The son's attorney submitted the report, dated August 30, 1985, to the opposing counsel.

Counsel for the physician asked the expert if he could prove his statement that the physician had violated the standard of medicine in 1962. The expert said that he did not have such proof but could find it if necessary. Although counsel for the physician requested the information, it was apparently not submitted.

The physician contended that the expert had failed to establish the proper standard of care in that his statements were his personal opinions and unsupported by any corroborating evidence.

The trial court dismissed the case. On appeal, the appellate court said that the trial judge appeared to erroneously question the competency of the expert because he was not in medical school until 1963.

The appellate court said that the support for such expert opinion could be based on what the witness had learned from personal experience or from persons with adequate training and experience. The court said that a physician who entered medical school after the alleged malpractice occurred could still express an opinion as to standards at the time of question. Further, the expert was not required to produce a treatise to support his opinion. The court reversed the trial court's judgment and sent the case back for trial. (Reprinted with permission from *The Citation*, American Medical Association, Volume 57, September 1, 1988)

Physician Involvement

PALMA E. FORMICA, M.D.*

Physicians must be involved, for the good of their patients and for the good of the profession.

The other day, one of my lunch partners complained that he was feeling oppressed and distressed by having to comply with so many regulations, prohibitions, and implied threats. He said he felt like the middleman in the health care scenario with the regulators on one side saying, "You can't." And the patients on the other side saying, "You won't." His complaints are not unique. In recent surveys, over 50 percent of physicians have indicated they believed their control over patient care was impeded by the intrusion of the government and other third parties into the doctor-patient relationship. Over 78 percent of respondents to an AMA attitudinal survey believed that cost-containment measures were affecting the quality of patient care; almost 80 percent of young physicians felt that cost-containment issues were compromising care.

The national survey of physician attitudes did not produce startling new information, especially for New Jersey. Having been pushed, squeezed, and pummeled, we know what regulations mean. We have seen firsthand what an all-payor DRG system has done to hospital care. Now that we have had the fat and the muscle, what can we do about this intrusion? We can sit back and moan with the prophets of doom and gloom, decrying the plight of our honored profession and do nothing, or we can stand fast and have the courage to really be the advocate of our patients.

In our professional relationships with our patients, we must never lose sight of our responsibility to them. We must never sacrifice the quality of care we give, or which we expect they should receive, from our health care system. No test nor treatment should be ordered which is not medically indicated. Nor should any test or treatment be withheld merely to cut costs or for personal gain.

When regulators intrude with their precertification rules, it is wise to document the name of the person collecting the information and the one making the determination.

If any decision does not coincide with your clinical judgment, ask for the criteria used to make that determination—under the Freedom of Information Act. This especially is important when dealing with the fiscal intermediary of Medicare. Ask for a peer review and the name and specialty of the reviewer. Appeal every decision you believe is detrimental to the health of your patient.

If you have problems with an insurer, The PRO, or the Medicare payors, report this to the Medical Society. The Committee on Utilization Review Systems has done an outstanding job in resolving problems. However, that Committee can handle only those cases which are referred to it.

Change can happen and sometimes will occur only when we make it happen. Physicians must be involved and must act for the good of their patients and for the profession—especially in the political arena. Our legislators make the laws; the bureaucrats, the regulations. Even Goliath was vulnerable. We can overcome.

It is time to be proactive. Let us not curse the darkness, when we can turn on the lights.

*Correspondence may be addressed to Dr. Formica, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

VERBAL THRESHOLD AND THE NEW JERSEY PHYSICIAN: Evaluating and Treating Patients Under the New Verbal Threshold Law.

*CME Pending.

New Jersey's new automobile legislation impacts physicians. Learn how to protect your medical fees under the new law at this year's most important seminar.

**The Meeting Place, Riverside Square Mall,
Route 4, Hackensack, N.J.**

Tuesday, March 14, 1989, 6 p.m.-10 p.m.

FACULTY: Samuel L. Davis, Esq.—Davis, Saperstein & Salomon, P.C., Hackensack, N.J.
David V. Habif, Jr., M.D.—Teaneck Radiology Center, Teaneck, N.J.
David M. Myers, M.D.—Orthopaedic Surgeon, Private Practice.



**THE
LEGAL
INSTITUTE
FOR
MEDICAL
EDUCATION**

Registration—Enrollment limited. Reserve now to ensure participation.
Tuition for seminar including materials and catered dinner.

Advance Registration and Program Materials	\$125.00
Door Registration and Program Materials	155.00
Audio Cassette Tapes (with Registration)	25.00
Audio Cassette Tapes	45.00
Audio Cassette Tapes and Program Materials	95.00
Office Manager Registration	25.00

Physician Name _____

Street _____ City/State/Zip _____

Business Phone (____) _____

Office Manager Name _____

I cannot attend, but send materials as indicated above. _____

Payment: Check Amount \$ _____ Master Card/Visa # _____

Send check and registration form to: Legal Institute For Medical Education (L.I.M.E.), 211 Essex Street, Suite 306, Hackensack, N.J. 07601 (201) 342-9362

The complete journal for family practice physicians

- Reaches 79,000 family physicians monthly
- Presents the most commonly seen patient problems in family practice
- Written by physicians for physicians
- The most current clinical updates in:
 - Cardiology Pediatrics Psychiatry
 - Diabetes Ob/Gyn Gastroenterology
- Provides 20 hours of CME Category 1 Credit

PRACTICAL • CLINICAL • EDUCATIONAL • CURRENT

Family Practice Recertification Greenwich Office Park 3, Greenwich, CT 06831 / (203) 629-3550

**FP
R**

Family Practice Recertification®



Epistaxis balloon catheter, page 20

DECEMBER 1987 / VOL. 9, NO. 12

FAMILY PRACTICE SKILL

- ◆ Controlling Epistaxis

CLINICAL ARTICLES

- Drug Therapy for Manic Illness
- Therapeutic Guidelines for Use of Nonsteroidal Antiinflammatory Drugs for Rheumatic Disorders: Salicylates

KEEPING CURRENT

- | | |
|---|--|
| Does a Definite Diagnosis Help Patients Get Better? | Can Obese Type II Diabetic Patients Use Fructose as a Sweetener? |
| Screening for Liver Metastases | |
| Significance of Elevated Erythrocyte Sedimentation Rates | Comparison of Diagnostic Tests for Evaluating Dementia |
| Glucose Tolerance and Pregnancy Complications Among Nondiabetic Women | Psychiatric Reactions Caused by Lidocaine Toxicity |

CUMULATIVE INDEX

It's February

HOWARD D. SLOBODIEN, M.D.*

February, the second month of our year, was the last lunar month in the Roman calendar.

The original calendar of ten months is attributed to Romulus, founder of Rome. Numa Pompilius, second King of Rome, elected after the year's hiatus following the death of Romulus, is said to have added January and February.

The Roman year originally began with March and ended with little February. March (Mars), April (Aphrodite), May (Maius, the greatest—Jupiter), and June (Juno) were named for major deities; the remaining six had numerical designation, beginning with Quintilius, the fifth month. The newly added January was held sacred to two-headed Janus, worshipped as a god of gods and overseer of the fortunes of mankind;

all doors were under his care and the commencement of the year, month, and day were regarded as sacred to him—perhaps explaining why January eventually was positioned as the first month of the year.

Poor February, from februaire, to purify, to expiate, also derives from the Roman divinity Februus, first identified with the Pan-like god Faunus, whose great feast, the Lupercalia, was celebrated on February 15. But Februus or Farunus hardly can be accorded the status of deities such as Janus, Mars, Aphrodite, Jupiter, and Juno.

February was further denigrated when the Caesars, first Julius and then Augustus, got their hands on the calendar. The Senate honored Julius's accomplishments in helping to set the vernal equinox in March by changing Quintilius to July, although Julius acted somewhat reticent about it. Augustus, not to be outdone, demanded equal treatment; Sextilis was changed to August. He also insisted on a month as long as Julius's; poor February suffered the ignominy of losing another day in order to accommodate him.

Many are pleased that February is so short, enabling them to get through it faster. Realistically, in our clime, January tends to be colder and March more blustery. In fact, February is known for precipitation, either rain or snow, and for flooding, which correlates well with its zodiac signs Aquarius and Pisces.

In addition to the feast of the Lupercalia, February also is known for Valentine's Day, Groundhog Day, and the birthdays of Lincoln and Washington. One of the less-heralded landmarks of the month, possibly responsible for unexplained and subconscious depression, is February 25th, when we commemorate the proclamation, in 1913, of the 16th amendment, which set up the income tax system.

Instead of moaning about the miseries of the month, perhaps we should use February as a time for reflection, for atonement, and for anticipation of spring and the rebirth of life. William Cowper understood February thusly:

I crown thee king of intimate delights.
Fire-side enjoyments, home-born happiness,
And all the comforts that the lowly roof
Of undisturb'd retirement, and the hours
Of long uninterrupted evening know.

*Correspondence may be addressed to Dr. Slobodien, editor-in-chief, *NEW JERSEY MEDICINE*, Two Princess Road, Lawrenceville, NJ 08648.

Senior Medical Courtesy



Figure 1—Dr. Formica and Assembly Speaker Chuck Hardwick at the Senior Medical Courtesy booth.

The annual one-day event, "Senior Games of New Jersey," was held last month at Kean College in Union. Sponsored by the Governor's Council on Physical Fitness and Sports and the New Jersey State Department of Community Affairs, the Medical Society of New Jersey contributed to this special day with our "Senior Medical Courtesy" booth, explaining to all attendees the value and benefits of this program. Dr. Palma Formica, president of MSNJ, along with Drs. Richard R. Lorber of Kenilworth and Joseph A. DiLallo of Summit answered questions asked by seniors who visited the booth.



Figure 2—Dr. Formica and Department of Community Affairs Commissioner Anthony M. "Doc" Villane, Jr., discuss the benefits of the MSNJ courtesy program.



Figure 3—Dr. Formica explains the Senior Medical Courtesy program to a booth visitor at Kean College in Union for the annual "Senior Games of New Jersey."

TEACHING PSYCHIATRY TO PRIMARY CARE RESIDENTS IN A COMMUNITY HOSPITAL

ROGER B. GRANET, M.D., MORRISTOWN*

Future psychiatrists will function less as clinicians and more as educators to primary care physicians. As such, psychiatrists must develop roles and programs to enhance the knowledge and skills of their physician colleagues, such as the program described.

The majority of psychiatric evaluation and treatment in the United States is provided by primary care physicians or by other nonpsychiatrist health professionals.^{1,2} Reasons for this pattern of delivery of care include the continued psychiatric manpower shortage;^{3,4} the industrialization of medicine, e.g. health maintenance organizations, where patients are screened by the family physician "gatekeeper,"⁵ or the persistent patient avoidance of formal psychiatric consultation in favor of primary care physician consultation.

Regardless of the specific cause of such patterns, current and future psychiatrists will function less in their traditional role as clinicians directly treating patients, and more as educators and consultants.⁶

Acceptance of this role shift requires a new focus for psychiatrists, not only in how they spend their professional time, but where and with whom they spend it. Specifically, since much of health care is provided in community settings, and since primary care residents represent the future physicians in those settings, a major refocus for psychiatrists might be as clinical educators; such educators should be competent clinicians who also are capable of teaching residents in community hospitals.

In reviewing the literature, there are reports of various training models, formats, and settings for house

staff education.^{2,7-9} However, there appears to be no description of a formal program for teaching psychiatry to primary care residents in a community hospital. The purpose of this article is to describe such a program and discuss the place for the clinical educator in the current health care system.

THE TEACHING PROGRAM

The setting of the teaching program was a 600-bed, university-affiliated community hospital in the north-eastern United States. The hospital maintained residency training programs in emergency medicine, internal medicine, pediatrics, radiology, and surgery, and a fellowship program in general dentistry.

The Department of Psychiatry which provided the clinical educators had no residency program, and was comprised predominately of voluntary attendings who were private practitioners.

The formal program was organized after many years of both informal and indirect teaching, e.g. patient

*Dr. Granet is director, consultation-liaison psychiatry, Morristown Memorial Hospital and clinical assistant professor of psychiatry, Cornell University Medical College, New York. This work was supported by a primary care residency program improvement grant from the Advisory Medical Education Council of the New Jersey State Department of Higher Education. Correspondence may be addressed to Dr. Granet, 20 Community Place, Morristown, NJ 07960.

consultations or lectures requested by residents or department chairmen. The Department of Psychiatry recognized the importance and necessity of a more structured program that would better meet the house staff needs. A consultation-liaison section was created and supported by a state grant for three years.

The overall goal of the educational program was to enhance the psychiatric knowledge of the nonpsychiatric graduate house staff. The specific educational foci were directed at increasing the understanding of the psychological aspects of medical illness and the enhancement of the residents' knowledge of the common psychiatric disorders they might encounter as practitioners.

The key to the teaching program was its clinical format; case references, supplemented by special grand rounds, became the basic teaching format.

Using a theoretical framework designed to follow a developmental and life cycle model, residents were encouraged to view the complex interaction of psychological, sociologic, and biologic variables at various stages in a patient's life; at various developmental phases patients react to medical illness in age-specific ways, e.g. a surgical procedure would have a particular impact on a latency-aged boy that would differ from that experienced by a geriatric female. In addition, psychiatric disorders would be expressed variably in diverse age groups, e.g. a major depression in adolescence might appear quite differently than a depression occurring in later life.

To enhance the psychiatric knowledge of the house staff, the educators developed a curriculum outline for themselves. Although the outline was designed to help the teachers focus their programs, it was not intended to be a rigid curriculum to be "thrust" on the residents. This curriculum included developmental and lifestyle models, e.g. Erikson, Freud, and Piaget; the major *DSM III* diagnoses; and theories of psychological reactions to medical illnesses.

The key to the teaching program was its clinical format. In a community hospital setting, the primary training focus is clinical—the residents display more interest in practical and observable, rather than theoretical, psychiatry. In turn, the attending psychiatrists are private practitioners and are most skilled and comfortable with clinical aspects of psychiatry. The case conferences, supplemented by special grand rounds, became the basic teaching format. These were conducted in a traditional manner: a question relating to a patient would be identified at the beginning of the conference, e.g., a diagnostic dilemma, a management issue. After presentation of the case by one of the residents, the psychiatrist or resident, when appropriate, would interview the patient and discussion would fol-

low. The educator always would attempt to use the developmental framework and apply it to both psychiatric aspects of medical illness and common psychiatric disorders.

To be successful, it was felt that the clinical educators should: work consistently with one house staff group over a period of time, e.g. the same instructor would meet with each resident group for at least a year; be receptive to the residents' educational needs; and focus on clinical rather than theoretical aspects of psychiatry.

Formal programs differing in their frequency of presentation were implemented successfully in pediatrics, internal medicine, surgery, emergency medicine, and general dentistry.

The pediatric house staff clinical case conferences were held alternate weeks and included topics such as the psychiatric aspects of chronic medical illness and adolescent substance abuse. Also, scheduled biweekly, the internal medicine conferences included diagnosis and treatment of depression in the elderly and the psychiatric aspects of myocardial infarctions in middle-aged men. The surgical resident conferences were held monthly and focused on such areas as post-operative delirium and adjustment disorders in the surgical patient. Discussions at the emergency medicine residents' bimonthly conferences were comprised of such topics as the evaluation of the suicidal patient and organic brain syndromes. The dentistry fellows met bimonthly and discussed such issues as management of the dental phobic patient and pharmacologic interactions in dentistry.

A basic evaluation procedure was used. Since this was a new experience for the educators and for the house staff, the evaluation was made directly by the teachers every six months. The educators were asked to give their impressions of the residents' understanding of new material and to answer the questions: Do you feel that the residents have a greater psychiatric knowledge than they had six months ago? Why or why not? This evaluation approach helped to forestall any resentment that might have been evoked had an attempt at formal testing of the house staff been made.

Although this clearly was a nonrigorous, unstructured evaluation process, the majority of the house staff, chairmen, and psychiatrists experienced the program as positive. This support was evidenced by excellent house staff attendance (which was voluntary) and by an increase in requests by the hospital residents for formal psychiatric consultations on their patients when necessary.

DISCUSSION

Several observations may be drawn from the community hospital experience:

1. The training of primary care residents by clinical psychiatric educators in a community hospital is a viable endeavor.

2. There clearly is a role for the clinical psychiatrist as educator outside the academic-medical school setting. Since most psychiatric care is provided outside the university setting by primary care physicians, it is critical that positive educational experiences be brought to those physicians in that environment.

3. A cornerstone of a successful program in a community setting is the provision of clinical education by dynamic practitioners, i.e. clinical educators.¹⁰

4. The case conference is preferable to formal lectures, and a positive conference experience appears to be linked to teacher flexibility and continuity (one teacher working with one house staff group over time).

5. A reasonably narrow focus is useful in such a program, e.g. instructing residents about psychological reactions to medical illness and common psychiatric disorders. In turn, a developmental and life cycle framework used by the teachers may fortify the focused teaching.

6. As the teaching experience unfolded in the hospital-based program, there was an increase in appropriate formal psychiatric consultations requested by the residents, which may be a reflection of the development of greater psychological-mindedness and knowledge gained by the house staff.

CONCLUSION

There would appear to be an important role evolving for the psychiatrist as clinical educator in a community hospital. As the health care system becomes more industrialized and yet remains somewhat convoluted, psychiatrists must define a clear vector for their future. A component of that vector will be the clinical psychiatrist as educator. It is hoped that as that role

is defined and developed further, future generations of primary care physicians and their patients will benefit from such educational intervention.

REFERENCES

1. Stoudemire A, Thompson T, Mitchell W, et al.: Family physicians' perceptions of psychological disorders. Survey report and educational implications. *Int J Psychiatry Med* 12:281-287, 1983.
2. Strain J, Pincus H, Houpt J, et al.: Models of mental health training for primary care physicians. *Psychosom Med* 47:95-110, 1985.
3. Fenton W, Leaf P, Moran N, et al.: Trends in psychiatric practice, 1965-1980. *Am J Psychiatry* 141:346-351, 1984.
4. Yager J, Scherber S: The career choice of psychiatry: A national conference on recruitment in psychiatry. *J Psychiatr Ed* 5:258-268, 1981.
5. Bittker T: Industrialization of American psychiatry. *Am J Psychiatry* 142:149-154, 1985.
6. Talbott J, Granet R: Careers in psychiatry: Options for the future. *Comprehensive Psychiatry* 25:263-277, 1984.
7. Strain J, Pincus H, Gise L, et al.: Mental health education in three primary care specialties. *J Med Educ* 61:958-966, 1986.
8. Strain J, Pincus H, Gise L, et al.: The role of psychiatry in the training of primary care physicians. *Gen Hosp Psychiatry* 8:372-385, 1985.
9. Strain J, Bender-Laitman L, Gise L, et al.: Mental health training programs in primary care: A bibliography. *J Psychiatric Ed* 7:208-231, 1983.
10. Pardes H: Medical education and recruitment in psychiatry (editorial). *Am J Psychiatry* 139:1033-1035, 1982.

AUTHOR INFORMATION

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. The goals are educational and informational. All material published in NEW JERSEY MEDICINE is copyrighted by MSNJ.

CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable

manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statement accompanying material offered to *New Jersey Medicine* must contain the following language and must be signed by all authors:

"In consideration of *New Jersey Medicine* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *New Jersey Medicine*.

SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods used in articles should be identified. Acknowledgements will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 40-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the

source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The **summary** of the article should not exceed 250 words; it should contain only essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

REPRINT ORDERS

Reprints may be ordered after the author is notified that the article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *New Jersey Medicine*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

QUALITY ASSESSMENT MECHANISM IN MEDICARE CONTRACT WITH THE PRO OF NEW JERSEY, INC.

DAVID I. KINGSLEY, M.D., EAST BRUNSWICK*

The Health Care Finance Administration awarded a new three-year (1988-1991) Medicare contract to The Peer Review Organization of New Jersey, Inc. The key elements of this contract are discussed.

The Health Care Finance Administration (HCFA) awarded a new three-year (1988-1991) Medicare contract to The Peer Review Organization (PRO) of New Jersey, Inc. A key element of this new contract dictates that a HCFA-designed severity level and scoring mechanism be utilized in performing quality of care review. The severity level and scoring system is not unique to New Jersey; under the new round of Medicare contracts, it is a requirement for peer review organizations throughout the country.

Although the severity level and scoring system is new, PRO involvement in reviewing for quality of care is not. The PRO of New Jersey, Inc. has been actively involved in reviewing for quality since its inception as a Professional Standards Review Organization (PSRO) in 1978, and it continued to do so when it became The Peer Review Organization for the state of New Jersey in 1984.

It is important to realize that PRO review is and will continue to be performed by local, active, practicing New Jersey physicians. All data are subject to strict federal confidentiality regulations. Constructive suggestions from the physician community are welcome and physician involvement in The PRO process is encouraged.

The HCFA rationale in imposing this severity level and scoring mechanism on the peer review process is

in response to physicians' concerns that PRO decisions were capricious and/or arbitrary. It also is indicative of HCFA's desire to develop a greater consistency in assessing quality of care review outcomes on both a state and national level. In addition, the new mechanism reflects an increased emphasis by HCFA on quality of care over utilization of services. Although not much flexibility was granted to The PRO of New Jersey, Inc. in terms of the overall design of the system, we were able to obtain permission from HCFA to modify to some extent the time frames for implementation of the system in this state.

HCFA-DESIGNED SEVERITY LEVELS

The severity levels being utilized as part of this system have been defined by HCFA as follows:

Level I: Medical mismanagement without potential for significant adverse effects on the patient.

Level II: Medical mismanagement with the potential for significant adverse effects on the patient.

Level III: Medical mismanagement with significant adverse effects on the patient.

HCFA has defined "significant adverse effect" as being unnecessarily prolonged treatment, complica-

*Dr. Kingsley is president of The Peer Review Organization of New Jersey, Inc. Correspondence may be addressed to Dr. Kingsley, The PRO of New Jersey, Inc., Brier Hill Court, Building J, East Brunswick, NJ 08816.

tion, or readmission and/or anatomical or physiological impairment, disability, or death.

The determination as to whether or not medical mismanagement has taken place will be made by The PRO Physician Reviewers in the course of their review of medical records.

Examples of the conditions warranting assignment of a severity level have been supplied by HCFA. These include:

Level I: 1. Inadequate medical record documentation (e.g. absent or inadequate history and physical, progress notes, preoperative/operative report, nurses notes, discharge summary).

2. Patient with mildly abnormal laboratory findings is discharged without adequate documentation, evaluation and/or appropriate plans for followup, such as a repeat laboratory test or outpatient workup (e.g. asymptomatic patient with mild bacteriuria and pyuria, discharged without adequate evaluation and/or appropriate plans for followup such as repeat urinalysis or urine culture).

3. Hospital-acquired decubitus ulcer, appropriate treatment initiated in a timely manner, and no significant harm results.

4. Failure to provide an effective discharge planning service but the patient's unmet needs were minimal (e.g. patient with slight hemiparesis discharged without adequate discharge planning).

The need of the involvement of physicians in the peer review process is and will continue to be important.

Level II: 1. Antibiotic sensitivity tests are not ordered for a patient with septicemia, the organism is not sensitive to the antibiotic administered; however, an appropriate antibiotic is selected in a timely manner, and no significant harm results.

2. Appropriate monitoring and timely recognition/treatment of potentially life-threatening arrhythmias is not provided for a patient with acute myocardial infarction, but no significant harm results.

3. Inappropriate administration of intravenous fluids or medication (e.g. excessive amount or rate, incorrect fluid or concentration of medication), error corrected prior to development of significant complications, and no significant harm results.

4. Electrolyte abnormalities are not monitored/treated in a timely manner, patient experiences marked mental status changes due to electrolyte imbalance, but recovers without long-lasting effects.

5. Elective major surgery performed on a patient with preoperative evidence of an unstable acute medical condition (e.g. acute myocardial infarction, pneumonia) but no significant harm results.

6. Patient with known severe COPD, administered an inappropriately high concentration of oxygen, is inadequately monitored and develops increasing somnolence; CO₂ retention is identified in a timely manner, appropriate treatment is initiated, and patient recovers without significant harm.

7. Life-saving/sustaining equipment (e.g. defibrillator, ventilator, telemetry) used in an emergency fails as a result of inadequate maintenance, but no significant harm results.

Level III: 1. Antibiotic sensitivity tests are not ordered for a patient with septicemia, the organism is not sensitive to the antibiotic administered, an appropriate antibiotic is not selected in a timely manner, and significant harm results (e.g. prolonged hospitalization, death).

2. Appropriate monitoring and timely recognition/treatment of potentially life-threatening arrhythmias is not provided for a patient with acute myocardial infarction, and significant harm results (e.g. prolonged hospitalization, cardiac arrest, death).

3. Inappropriate administration of intravenous fluids or medication (e.g. excessive amount or rate, incorrect fluid or concentration of medication), error not corrected in a timely manner, and significant harm results (e.g. prolonged hospitalization, pulmonary edema, cardiac arrest, death).

4. Electrolyte abnormalities are not monitored/treated in a timely manner, patient experiences marked mental status changes due to electrolyte imbalance, falls, and sustains a hip fracture, which requires surgery.

5. A patient who is unstable at discharge is readmitted for the same or related condition for treatment that was not provided during the initial admission (e.g. a patient discharged without treatment for a urinary tract infection discovered prior to discharge is readmitted with septicemia due to the urinary tract infection; a hypertensive patient without prior neurological deficits develops progressive neurological deficits on the day of discharge; patient is discharged and is subsequently readmitted with hemiparesis).

6. Elective major surgery on a patient with preoperative evidence of an unstable acute medical condition (e.g. acute myocardial infarction, pneumonia) and significant harm results (e.g. unnecessarily prolonged hospitalization, infarct extension, death).

HCFA-ASSIGNED WEIGHTED SCORES

HCFA has assigned a weighted score to each severity level as follows: Level I: 1; Level II: 5; Level III: 25.

IMPLEMENTATION OF THE SYSTEM

The PRO will notify the attending physician of a potential quality problem only after two PRO physicians have reviewed the medical record and both have agreed that a potential quality problem exists. The letter to the attending physician will identify what The PRO has identified as the problem and it will also indicate a tentative severity level as well as the consequences of that severity level in the event it is eventually imposed. At this point, the attending physician is given 30 days in which to respond to questions.

The attending physician's response will be reviewed by another PRO physician reviewer who, to the extent possible, will be a specialist in the same field as the attending physician. It also will be reviewed by the Quality Assurance Committee which is composed of, at a minimum, three physician reviewers (not including the original PRO physician reviewers). Therefore, a severity level and weighted score is not attached to

a quality problem until at least five to six PRO physicians have reviewed the case and have determined that a quality problem exists.

Notification regarding confirmed quality problems will be sent to the attending physician after 3 points have been attained in a calendar quarter. Following this, The PRO will consider any new information submitted by the attending physician with regard to the case and may alter its original determination. It is important to note that HCFA's Scope of Work for peer review organizations throughout the country does not include this option of allowing for additional documentation after a quality problem has been confirmed. The PRO of New Jersey persuaded HCFA to include this last step in our new contract, so as to increase our options of response and to allow for continued input from practicing physicians.

PRO INTERVENTIONS

HCFA requires that the interventions taken by The PRO of New Jersey, Inc. be based on the number of points attained by a physician and/or hospital in a given calendar quarter. These interventions will be as follows:

Notification: The PRO will send written notification to the attending physician and/or hospital when a determination is made that a quality problem exists, or if 3 to 5 points are attained in a calendar quarter.

Education: The PRO will suggest that the attending physician and/or hospital seek continuing education if 10 points are attained in a calendar quarter.

Intensified Review: The PRO will conduct an intensified review of the attending physician and/or hospital if 15 points are attained in a calendar quarter.

Other: The PRO may institute prepayment and/or preadmission review of the attending physician and/or hospital or, if it is a physician problem, The PRO may refer the problem to the hospital for corrective action if 20 points are attained in a calendar quarter.

Sanctions: If 25 points are attained in a calendar quarter, The PRO's Quality Assurance Committee may make the determination that the case be referred to the Sanctions Committee if it meets the definition of a gross and flagrant violation. In addition, The PRO's Board and/or Executive Committee will determine whether or not the Board of Medical Examiners should be notified.

CONFIDENTIALITY

As in the past, The PRO of New Jersey, Inc. is bound by the confidentiality regulations imposed by the federal government. Therefore, the results of the severity level and scoring system will not be made available to the general public.

PHYSICIAN PARTICIPATION IN THE PEER REVIEW PROCESS

HCFA's introduction of this new severity level and scoring mechanism is a significant indication that the federal government is becoming increasingly involved in assessing physician performance. Therefore, the need for the involvement of active, practicing physicians in the peer review process is and will continue to be vitally important. As physicians, it is in our best interests to take an active role in the development and refinement of the peer review process.

Editor's Note. We are pleased that the president of The PRO of New Jersey, Inc. has accepted an invitation to publish in our journal—in keeping with our policy of expanding the avenues of communication with our members.

Although the continual increase in regulatory pressure is depressing, many of us feel we have at least a fighting chance to obtain fair play; past actions by the state PRO suggest this. When they ask for physician input, they mean it. Nonetheless, HCFA sets the guidelines and allows few deviations, so beware.

It should be noted that hospitals also are under surveillance and are subject to sanctions; no one escapes Big Brother.

ARMY RESERVE OFFERS NEW FINANCIAL INCENTIVES FOR RESIDENTS IN ANESTHESIOLOGY AND SURGICAL SPECIALTIES



If you are a resident in Anesthesiology, Orthopaedic Surgery, or General Surgery including Neurosurgery, Colon/Rectal, Cardiac/Thoracic, Pediatric, Peripheral/Vascular and Plastic Surgery, the Army Reserve has a new and exciting opportunity for you. The New Specialized Training Assistance Program will provide you with financial incentives while you're training in one of these specialties.

Here's how the program can work for you. If you qualify, you may be selected to participate in the Specialized Training Assistance Program. You'll serve in a

local Army Reserve medical unit with flexible scheduling so it won't interfere with your residency training, and in addition to your regular monthly Reserve pay, you'll receive a stipend of \$678 a month.

You'll also have the opportunity to practice your specialty for two weeks a year at one of the Army's prestigious Medical Centers

Find out more about the Army Reserve's new Specialized Training Assistance Program. Call (collect) your U.S. Army Medical Department Reserve Personnel Counselor: **Major Claudia Gibson**

609-667-8190

Collect

ARMY MEDICINE. BE ALL YOU CAN BE.

DIAGNOSTIC DILEMMA OF AORTIC ANEURYSMS: INTERNIST'S PERSPECTIVE

ROBERT C. MAYER, M.D., AND ELLIOT FRANK, M.D., NEPTUNE*

Aortic aneurysms mimic many medical diseases. We studied 23 patients with autopsy-proved aortic rupture. Several clues suggesting the correct diagnoses were not elicited or their significance appreciated. A high index of suspicion is critical for rapid diagnosis of this lethal disease.

Aortic aneurysms are associated with significant morbidity and mortality. Although classic presentations—severe pain with hypotension and an obvious expansile mass—present little diagnostic difficulty, unusual presentations may lead to significant diagnostic delay, and result in catastrophic aortic rupture. Recently, three patients had unusual presenting signs and symptoms and the diagnosis of aortic aneurysm initially was not considered. Subsequently, one of these three patients was diagnosed early enough to undergo successful surgical correction. In the other two patients, aortic rupture was diagnosed at autopsy. As a result, a 13-year retrospective chart review was undertaken to identify patients seen between 1972 and 1986 who were diagnosed at autopsy as having terminal aortic rupture.

MATERIALS AND METHODS

At Jersey Shore Medical Center, a 500-bed acute care facility, a retrospective chart review identified 41 patients with an autopsy diagnosis of ruptured aortic aneurysm between January 1971 and March 1986. Twenty of the 41 patients had arrived in circulatory collapse, expired within 24 hours of arrival, and were excluded from this study. The remaining 21 patients and 2 additional patients form the basis of this study. Twenty-three charts were reviewed and data was ab-

stracted concerning age, sex, chief complaint, physical findings, laboratory analysis, radiology studies, cardiovascular history, associated signs and symptoms, and initial diagnostic impression. Patients were divided into two groups: group 1 consisted of 12 patients with thoracic aneurysms; group 2 was composed of 11 patients with abdominal aneurysms.

RESULTS

The 23 patients included 14 males and 9 females, with a mean age of 67 years and a range of 52 to 89 years. Fifteen patients were in their sixth or seventh decade of life, with the remaining 8 patients being equally divided between the fifth and eighth decades of life. Twelve patients (group 1) had thoracic aneurysms, pathologically described as dissecting in 8 patients, and saccular in 4 patients. Eleven patients (group 2) had saccular abdominal aortic aneurysms.

The most frequent chief complaint was pain, expressed initially by 17 patients (74 percent). Thirteen of these 17 patients described an acute onset of their pain, while the remaining 4 patients described a sub-

*Dr. Mayer is a resident in anesthesiology, St. Joseph's Hospital and Medical Center, Paterson. Dr. Frank is associate program director, Department of Medicine, Jersey Shore Medical Center, Neptune. Correspondence may be addressed to Dr. Frank, Jersey Shore Medical Center, 1945 Route 33, Neptune, NJ 00754.

TABLE 1

**Chief Complaint of 23 Patients
with Subsequent Aortic Rupture**

	Thoracic	Abdominal	Total
Pain, acute	8	5	13
Pain, subacute	1	3	4
Syncope	1	1	2
Shortness of breath	1	0	1
Hemoptysis	1	0	1
Abdominal mass	0	1	1
Asymptomatic	0	1	1

acute onset of greater than 24 hours in duration. Other chief complaints included syncope,² shortness of breath, hemoptysis, and enlarging abdominal mass. One patient had an asymptomatic aneurysm found incidentally while being admitted for an unrelated disorder (Table 1). A chief complaint of pain was equally common with thoracic (75 percent) and abdominal (73 percent) aneurysms. However, the onset and location of the pain differed between the two groups. Pain was acute in 8 of the 9 patients (89 percent) with thoracic aneurysms, but only in 5 of 8 patients (63 percent) with abdominal disease. The pain associated with the thoracic aneurysms was nonspecific in location, being reported in the jaw,¹ chest,⁴ abdomen,² and lumbar spine.² In contrast, the pain in group 2 was localized to the abdomen in 7 patients, and to the lumbar spine in 1 patient.

Vomiting was noted in seven patients (30 percent)—four patients in group 1, and three patients in group 2. Neurologic symptoms, syncope,³ or confusion² were present in five patients—four patients with thoracic aneurysms, but also in one patient with an abdominal aneurysm.

The most common physical findings were abnormal blood pressure, tachycardia, and abdominal mass. Hypotension (systolic blood pressure less than 90 mmHg) or hypertension (blood pressure greater than 150 mmHg systolic and 90 mmHg diastolic) occurred in 15 of the 23 patients (65 percent). Tachycardia was present in 11 patients (48 percent). Hemodynamic alterations were common equally in both groups. Seven patients in group 2 had a palpable abdominal mass (Table 2).

A history of hypertension requiring medication was common (70 percent) and was documented in eight patients in each group. A history of coronary artery disease, manifested as angina or previous myocardial infarction, was obtained from six patients (26 percent) while a history of claudication was noted in only two patients. Its absence, however, was infrequently documented. Only one patient had a history of cerebral vascular accident (Table 3).

Plain chest x-rays were abnormal in 21 of the 23 patients (91 percent). Nonspecific findings were most common: cardiomegaly was present in 12 patients and tortuous aorta was present in 10 patients. Both of these abnormalities were slightly more prevalent in the thoracic group. Pleural effusion was seen in 2 patients and a widened mediastinum in 1 patient with thoracic

TABLE 2

Signs and Symptoms

	Thoracic	Abdominal	Total
Syncope/vertigo	2	1	3
Confusion	2	0	2
Vomiting	4	3	7
Tachycardia	6	5	11
Tachypnea			
720 breaths per minute	2	0	2
Blood pressure >150/90	4	4	8
Blood pressure <90 systolic	4	3	7
Abdominal mass	0	7	7

TABLE 3

Medical History

	Thoracic	Abdominal	Total
Cerebrovascular accident	1	0	1
Hypertension	8	8	16
Angina/myocardial infarction	3	3	6
Claudication	0	2	2

aneurysms. Two normal chest films were found in the abdominal group (Table 4).

An accurate initial diagnosis of aortic aneurysm was formulated in 10 of 23 patients (43 percent). However, the initial diagnosis was correct in only 3 patients (25 percent) with thoracic aneurysms as compared with 7 patients (63 percent) in group 2. Three patients with correctly diagnosed thoracic aneurysms presented with acute chest pain and suggestive chest x-rays characterized by widened mediastinum or markedly tortuous aorta. All 3 patients had pathologically documented dissection. The 9 misdiagnosed patients in the thoracic group were worked up for myocardial infarction,² pulmonary embolism,² cerebrovascular accident/transient ischemic attack (CVA/TIA),² renal colic,¹ acute cholecystitis,¹ and lumbosacral osteoarthritis.¹

The seven correctly diagnosed abdominal aortic aneurysms all had a palpable mass; none of the four misdiagnosed patients had a palpable abdominal mass. These patients were thought to have renal colic,² diverticulitis,¹ and gastroenteritis¹ (Table 5).

DISCUSSION

This series, representing patients with autopsy-proved aneurysm, by design was skewed to identify patients with unusual presentations. Nonetheless, pain was the most common presenting complaint, noted by 16 of the 23 patients. The onset and location of the pain was associated mainly with the type of pathology. Seven of the eight thoracic dissections had acute pain that was nonspecific in location. One patient had a dissection without pain.

Classically, a patient with thoracic aortic dissection describes the abrupt onset of excruciating chest or scapular pain. In many cases, the pain may migrate to

the neck, arm, or epigastrium.^{1,4} Painless dissection is uncommon, but well documented.^{5,6}

In contrast to the acute pain which characterized most patients with thoracic dissections, saccular thoracic aneurysms, presented with multifarious signs and symptoms including acute pain, subacute pain, syncope, and shortness of breath with hemoptysis in our series. Likewise, the pain associated with our abdominal cases either was subacute or acute in onset, though it generally did remain localized to the abdomen or lumbosacral area. Such saccular aneurysms of the abdominal aorta tend to be asymptomatic until reaching a diameter of approximately 5 cm. Aneurysms exceeding this may produce a dull abdominal or back pain. Development of new abdominal or back pain in a patient with previous asymptomatic aneurysm indicates aneurysmal expansion and often signals impending rupture.^{7,8}

Sixteen patients (70 percent) had hypertension of sufficient severity to require pharmacologic control. This is consistent with previous reports documenting hypertension in 70 to 90 percent of patients with acute dissection of the thoracic aorta, and suggests that it may be an important etiologic factor.⁹

Abdominal aortic aneurysms most commonly are associated with atherosclerosis for which hypertension is an established major risk factor. Atherosclerotic disease of the aorta may be an isolated finding, but frequently represents a generalized atherosclerotic process. Thus, evidence of atherosclerosis in the cardiovascular tree raises the index of suspicion for the presence of aortic aneurysm.

Several patients (30 percent) had systolic blood pressure of less than 90 mmHg. Hypotension coupled with a history of hypertension creates the suspicion of possible impending vascular collapse due to aneurysm. Unfortunately, this simplified scenario often is complicated by other nonspecific signs and symptoms. It is important to consider an aortic aneurysm when an apparent myocardial infarction is accompanied by a normal electrocardiogram.¹

Neurologic disturbances, including syncope, vertigo, confusion, or weakness, were present in four patients with thoracic aneurysm and one patient with abdominal aneurysm. Neurologic disturbance associated with dissecting aneurysm is not uncommon and well documented, and when present may enhance diagnostic accuracy.^{1,4,6,10,11} Initially, Weisman and Adams classified nervous system involvement in dissecting aneurysms into three categories, depending on whether peripheral nerve, the spinal cord, or the brain was involved. Their review noted that the frequency of correct diagnosis was 80 percent in cases associated with neurologic symptoms versus 55 percent without neurologic involvement.¹⁰ Hirst and associates classified neurologic manifestations into two types, disturbances of consciousness (syncope, confusion, or dizziness) or complex disturbances (monoplegia or paraplegia). Their exhaustive review of 505 cases of aortic dissections found only 5 percent of cases show disturbances of consciousness.¹¹ More recently, Slater reviewed 124 dissections and found 19 percent to have associated neurologic manifestations.²

A correct diagnosis of thoracic aneurysm was made in only three instances in our series. In these cases,

we found the chest radiographs played a key diagnostic role. One case was associated with mediastinal widening; the other two patients had a tortuous aorta noted on chest x-ray. Interestingly, a total of ten patients, six patients from the thoracic group and four patients from the abdominal group, had a tortuous aorta. It would appear that roentgenographic evidence of a tortuous aorta could provide an important clue to the diagnosis of both thoracic and abdominal aneurysm in the appropriate context. Cardiomegaly was noted in seven patients (58 percent) and five patients (45 percent) of the thoracic and abdominal groups, respectively. This plain film finding might also serve as a clue that severe cardiovascular changes may have resulted from chronic hypertension.

Pleural effusion, associated with chest pain and tachypnea, was seen in 2 patients with thoracic aneurysms. Although these 2 patients were thought to have pulmonary emboli, autopsies confirmed aortic dissections with rupture into the pleural cavity. A thorough review of plain chest film radiographic signs in aortic dissection has been presented by Doroghazi and Slater.¹² Although plain chest film findings may be helpful, they are nonspecific. Computed tomographic (CT) scanning and ultrasound are clearly more reliable studies and have the potential for immediate, accurate diagnosis. Recently, a seven-year study of CT scanning in the diagnosis of abdominal aortic aneu-

TABLE 4			
Plain Posteroanterior Chest Film Findings			
	Chest X-ray		
	Thoracic	Abdominal	Total
Normal	0	2	2
Tortuous aorta	6	4	10
Cardiomegaly	7	5	12
Pleural effusion	2	0	2
Widened mediastinum	1	0	1

TABLE 5			
Initial Diagnostic Impressions			
	Initial Diagnosis		
	Thoracic	Abdominal	Total
Aneurysm	3	7	10
Myocardial infarction	2	0	2
Pulmonary embolism	2	0	2
Cerebrovascular accident/ transient ischemic attack	2	0	2
Renal colic	1	2	3
Acute cholecystitis	1	0	1
Diverticulitis	0	1	1
Gastroenteritis	0	1	1
Osteoarthritis	1	0	1
Total	12	11	23

rysms evaluated 226 patients. In 15 patients, no aortic pathology was seen. In the other 211 patients, the diagnosis of abdominal aneurysm was made and confirmed by other techniques and/or surgery. Scans were obtained at 2 cm intervals beginning at the xiphoid and ending below the umbilicus. One cm images were utilized to clarify the relationship of the aneurysm to the renal arteries. These authors noted that CT scanning was superior to ultrasound for demonstrating the relationship of the renal arteries to the aneurysm, for determining thoracic extension, and for obese patients or those with large amounts of intestinal gas, i.e. ileus or barium.¹³ Other studies have demonstrated the superiority of CT as compared to ultrasound for determining the exact diameter of abdominal aneurysms.^{13,14} The diagnosis of aortic dissection by ultrasound also has limitations due to difficulties in identifying an intimal flap,¹⁵ though sensitivity can be enhanced by combining two-dimensional and m-mode echocardiography and by imaging from multiple anatomic sites.¹⁶ On the other hand, complications of dissection such as pericardial effusion or aortic valvular insufficiency are identified more easily by echocardiography than by CT scanning and ultrasound can be performed at the bedside without the need to transfer a critically ill patient to the x-ray department. The relative advantages of either CT scanning or ultrasound notwithstanding, either modality can provide a rapid and reliable means for the diagnosis of potentially life-threatening aneurysms.

A correct diagnosis of an abdominal aneurysm was made in 7 of 11 patients (64 percent). All of these correctly diagnosed cases had a palpable abdominal mass, but only 2 patients had the classic triad of abdominal pain, pulsatile mass, and hypotension. The 4 misdiagnosed patients in the abdominal group were without a palpable mass, and a diagnosis of aortic aneurysm was not considered despite the presence of abdominal or back pain. Two of these 4 patients also had hypotension, but apparently pain and hypotension in the absence of abdominal mass, was not sufficient to evoke suspicion of an abdominal aneurysm. All 4 patients abruptly expired while being investigated for other disease processes. We conclude that in patients over 50 years old, an abdominal aortic aneurysm should be considered in every case of abdominal pain, despite the absence of a palpable mass.

A common misdiagnosis in our abdominal group was renal colic. Both renal colic and abdominal aneurysms frequently present with acute onset of severe flank or groin pain. It is interesting to note that in 1905, Osler commented in his review of 16 cases of abdominal aortic aneurysm, that this disease "may simulate the pain of gallstones, or renal colic, or of appendicitis."¹⁷ Darling's clinicopathic study of 60 consecutive patients with abdominal aortic rupture, found flank or groin pain on initial presentation in 16 patients.¹⁸

Since abdominal aortic aneurysm can mimic or cause urologic symptoms, it must be suspected even when abdominal pain is accompanied by supportive urologic findings. Pryor reviewed 44 cases of ruptured abdominal aneurysm and found that 15 patients (34 percent) presented with urologic symptoms, with two thirds of these misdiagnosed.¹⁹ Culp and Berantz re-

viewed 400 patients with abdominal aortic aneurysms and reported that 10 percent presented with symptoms suggesting genitourinary pathology.²⁰ This figure approximates our finding of 18 percent. Ayyat et al. reviewed the simulation of urologic disorders by abdominal aortic aneurysm and also emphasized that abdominal aneurysms may masquerade as a multitude of urologic problems.²¹

SUMMARY

Ruptured aortic aneurysms are associated with significant morbidity and mortality. Because of the availability of effective therapy, early diagnosis becomes extremely important. Emergency CT or ultrasound studies can provide critical information. It is important to appreciate the diagnostic dilemma of aortic aneurysms in a variety of apparent neurological, cardiac, pulmonary, urologic, or gastrointestinal diseases. While emergency CT or ultrasound studies may aid in diagnosis, the critical factor in accurate diagnosis is a high index of suspicion.

REFERENCES

1. Cooke JP, Staff RE: Progress in the diagnosis and management of aortic dissection. *Mayo Clin Proc* 61:147-153, 1986.
2. Slater EE, DeSanctis RW: The clinical recognition of dissecting aortic aneurysm. *Am J Med* 60:625-633, 1976.
3. Wheat MW Jr: Acute dissecting aneurysm of the abdominal aorta: Diagnosis and treatment—1979. *Am Heart J* 99:373-387, 1980.
4. DeSanctis RW, Doroghazi RM, Austen WG, Buckley MD: Aortic dissection. *N Engl J Med* 317:1060-1067, 1987.
5. Cohen S, Littman D: Painless dissecting aneurysm of the aorta. *N Engl J Med* 271:143, 1964.
6. Greenwood WR, Robinson MD: Painless dissection of the thoracic aorta. *Am J Emerg Med* 4:330-333, 1986.
7. Ottinger LW: Ruptured arteriosclerotic aneurysms of the abdominal aorta. *JAMA* 233:147, 1975.
8. Stephenson HE, Lockhart CG: Treatment of the ruptured abdominal aorta. *Surg Gynecol Obstet* 14:855, 1977.
9. Slater EE, DeSanctis RW: *Diseases of the Aorta in Heart Disease Textbook of Cardiovascular Medicine*. Philadelphia, PA, WB Saunders, 1984, pp. 1540-1571.
10. Weisman AD, Adams RD: Neurologic complications of dissecting aortic aneurysm. *Brain* 67:69-92, 1940.
11. Hirst AE Jr, Johns VJ, Kime SW: Dissecting aneurysm of the aorta: A review of 505 cases. *Medicine* 37:271-279, 1958.
12. Doroghazi RM, Slater EE: Aortic dissection. New York, NY, McGraw-Hill, 1983, pp. 71-87.
13. Gomes MN, Wallace RB: Present status of abdominal aortic imaging by computed tomography. *J Cardiovasc Surg* 25:1-6, 1985.
14. Gomes MN, Schellinger D, Hugnagel CA: Abdominal aortic aneurysms: Diagnostic review and new techniques. *Ann Thorac Surg* 27:479-488, 1979.
15. Fergnabrums H: *Echocardiography, 3rd Edition*. Philadelphia, PA, Lea & Febiger, 1981.
16. Buubenheimer P: Fortschritte in der Diagnose der Aortendissektion durch TM- und 2D-Echographie. *Cardiology* 68 (Suppl 1): 66, 1981.
17. Osler W: Aneurysms of abdominal aorta. *Lancet* 1089-1096, 1905.
18. Darling RC: Ruptured arteriosclerotic abdominal aortic aneurysm. *Am J Surg* 119:397-401, 1970.
19. Pryor JP: Diagnosis of ruptured aneurysm of abdominal aorta. *Br Med J* 3:735-736, 1972.
20. Culp OS, Bernatz PE: Urologic aspects of disease in the abdominal aorta. *J Urol* 86:189, 1961.
21. Ayyat F, Comfot D, Hudson HC: Abdominal aortic aneurysm simulating urologic disorders. *J Med Assoc State Ala* 51:36, 1981.

UPRIGHT AND SUPINE FLOW-VOLUME CURVES IN PATIENTS WITH OSA

JEFFREY NAHMIA, M.D., AND MONROE S. KARETZKY, M.D., NEWARK*

Abnormalities of the flow-volume curve obtained during routine spirometry are indicators of the obstructive sleep apnea syndrome. The sensitivity of this maneuver as a screening test is enhanced when it is performed in the supine and upright postures.

The obstructive sleep apnea (OSA) syndrome results from repetitive collapse of the upper airway during sleep usually at the level of the oropharynx or hypopharynx.¹ Airway closure causes asphyxia; the magnitude of the resulting hypoxemia and hypercapnia being dependent upon the duration and frequency of the obstructive episodes. Eventually an arousal response intervenes, restoring genioglossal tone and re-establishing patency of the occluded airway, with resumption of effective ventilation and an increase in oxygenation towards normal until the next episode occurs.

Since the size of anatomic components of the extrathoracic airway is thought to play a major etiologic role in causing the upper airway obstruction of OSA, direct and indirect assessments of upper airway diameter have been attempted by utilizing such methods as fiberoptic visualization,² cephalometrics,^{3,4} acoustic reflection,⁴ computerized tomography,⁵ and flow volume curves (VVC).⁶ The latter is a noninvasive, rapid, and inexpensive method for evaluating patency.

It recently has been reported that pharyngeal size decreases on assuming the supine position and suggested that the compromised pharyngeal airway of the obese snorer may only reach a critical diameter on assuming the supine posture.⁷

The objective of this study was to determine if

supine, in addition to upright, spirometric testing improves the sensitivity of the analysis of VVC to detect upper airway obstruction, without decreasing the specificity for predicting OSA.

METHODS

Forty-eight consecutive patients with snoring plus a history consistent with the OSA syndrome underwent all night polysomnography at the Newark Beth Israel Sleep Disorders Center. This included the following continuous recordings: electroencephalography (C3/A2, C4/A1), submental electromyography, right and left electro-oculography, and a V2 electrocardiogram (ECG). In addition, nasal and oral airflow were measured via thermistors, abdominal and thoracic movements by pneumobelt, and continuous measurement of oxygen saturation via ear oximetry. Sleep scoring was performed as per standard criteria.⁸

An obstructive apnea was defined as cessation of oral and nasal airflow for ten seconds or longer in the presence of continuous respiratory effort. Central apneas were cessation of nasal and oral airflow for ten seconds or longer, but with no respiratory effort recorded, while mixed apneas were defined as apneas

*Drs. Nahmias and Karetzky are affiliated with the pulmonary division, Newark Beth Israel Sleep Disorders Center. Correspondence may be addressed to Dr. Nahmias, Newark Beth Israel Medical Center, 201 Lyons Avenue, Newark, NJ 07112.

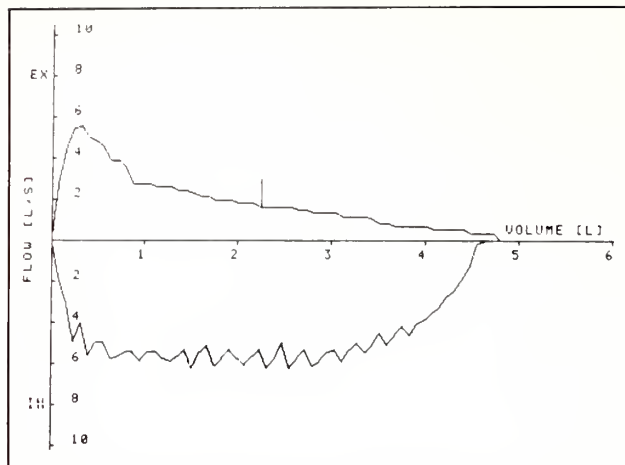


Figure 1—Flow-volume curves demonstrating sawtoothing.

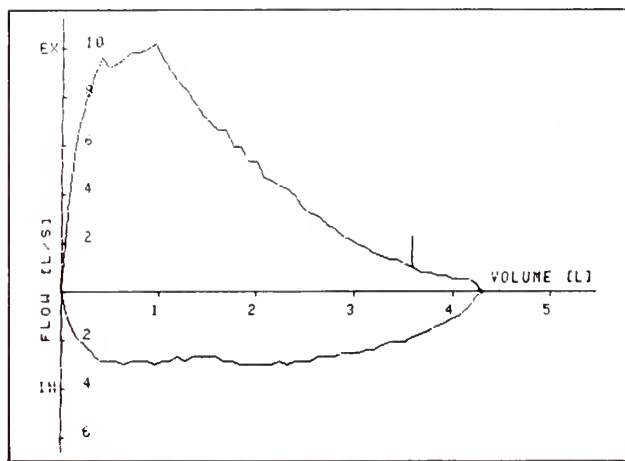


Figure 2—Flow-volume curves demonstrating flattening of inspiratory limb.

with an initial central component followed by an obstructive component. Mixed apneas were included with obstructive apneas in statistical analysis as suggested previously.⁹ Hypopneas were defined as a 50 percent or greater reduction in airflow accompanied by a 4 percent or greater decrease in oxygen saturation.

Patients with an apnea index (AI), number apneas/hr total sleep time (TST), of greater than five or an apnea plus hypopnea index (A + HI), number of apneas plus hypopneas/hr TST, greater than ten, were classified as having OSA. Apneas plus hypopneas were termed disordered breathing events (DBE).

The morning after the all-night polysomnogram, all patients generated a maximal flow-volume curve with the technician, emphasizing a maximal inspiratory maneuver as well as maximum expiratory effort. Three criteria of the VVC were used to detect upper airway obstruction (UAO). The first was sawtoothing, defined as three or more consecutive peaks and troughs in the mid-50 percent of the vital capacity in either the inspiratory or expiratory limb (Figure 1), a second was flattening of the inspiratory limb (Figure 2), and a third was mid-flow rate ratio (FEF50/FIF50) greater than or equal to one (Figure 3). The technician was blind to the results of the previous night's polysomnographic studies. Thirty-six of the 48 patients also had their lung volumes measured in both the upright and supine positions by the helium dilution

method (Jaeger Transferscreen, Rockford, IL). This resulted in a nonselected distribution of 15 of the 20 patients who did not have OSA (non-OSA), and 21 of the 28 patients with OSA.

Arterial blood gases were obtained in the upright and supine positions in 17 of the 20 patients without OSA, and in 27 of the 28 patients whose polysomnograms were positive for OSA.

All values are given as means plus standard error of the means (SEM). Statistical analysis was performed utilizing the student "t" test (two tailed) with a $P < 0.05$ considered significant. The following equations also were used in the data analyses:

$$\text{Sensitivity} = \frac{\text{true positives}}{\text{true positives} + \text{false negatives}}$$

$$\text{Specificity} = \frac{\text{true negatives}}{\text{true negatives} + \text{false positives}}$$

$$\text{Positive Predictive Value} = \frac{\text{true positives}}{\text{true positives} + \text{false positives}}$$

$$\text{Negative Predictive Value} = \frac{\text{true negatives}}{\text{true negatives} + \text{false negative}}$$

RESULTS

Patient Characteristics. Polysomnographic analyses revealed 20 of the 48 patients did not have OSA. Twenty-eight patients were diagnosed as having the OSA syndrome with a mean AI of 34.4 ± 7.5 apneas/hr TST and a mean A + HI of 51.3 ± 7.6 DBE/hr TST (Table 1). The groups did not differ in age or height. The OSA group was heavier than the non-OSA group, whether expressed in absolute or relative terms (Table 1).

Pulmonary Function Tests and Arterial Blood Gases. There were no intragroup differences between upright and supine flow rates. However, expiratory flow rates and forced vital capacity (FVC) were greater in the OSA group in both the upright and supine postures (Table 2).

There were no differences between upright and supine lung volumes when intragroup comparisons were made. There also were no differences between OSA and non-OSA groups with the exception of the upright total lung capacity (TLC), which was greater in the OSA group (Table 2).

Arterial blood gas measurements revealed no differences between upright and supine values when intragroup comparisons were made. However, in the upright position, the PaO_2 was lower and PaCO_2 was higher in the OSA group. In the supine position, PaCO_2 was higher in the OSA group, but the PaO_2 did not differ between groups. In accordance with the PaCO_2 , the pH was lower both upright and supine in the OSA group. (Table 3).

Flow Volume Curves. Table 4 demonstrates the sensitivity and specificity of each criteria for detecting upper airway obstruction in the upright, supine, and combined upright plus supine postures. Twelve of the 28 patients in the OSA group demonstrated sawtoothing in their upright or supine VVC, while only 2 of the 20 patients in the non-OSA group had sawtoothing present. The addition of supine testing did

TABLE 1
Patient Characteristics

n	OSA	non-OSA
	28	20
Age (yr)	48.1 ± 2.6	49.3 ± 2.8
Height (in)	67.4 ± 0.7	66.0 ± 0.9
Weight (lbs)	253.0 ± 12.7	203.6 ± 9.9*
% IBW	148.1 ± 7.2	124.3 ± 5.2**
AI (apnea/hr)	34.4 ± 7.5	0.3 ± 0.3*
A+HI (DBE/hr)	51.3 ± 7.6	1.0 ± 0.5*

*P<0.005

**P<0.05

TABLE 2

Upright and Supine Pulmonary Function Tests

	OSA	non-OSA
FEV1 (L)		
Upright	2.72 ± 0.15	2.11 ± 0.20*
Supine	2.50 ± 0.13	1.91 ± 0.19*
FVC (L)		
Upright	3.48 ± 0.20	2.76 ± 0.24**
Supine	3.25 ± 0.18	2.52 ± 0.23*
RV (L)		
Upright	2.76 ± 0.33	2.08 ± 0.29
Supine	2.47 ± 0.23	2.65 ± 0.27
FRC (L)		
Upright	3.23 ± 0.28	2.72 ± 0.21
Supine	2.94 ± 0.22	2.90 ± 0.24
TLC (L)		
Upright	6.02 ± 0.49	4.88 ± 0.40**
Supine	5.63 ± 0.38	5.38 ± 0.47

(Intergroup, *P<0.01; **P<0.05)

TABLE 3

Upright and Supine Arterial Blood Gases

	OSA	non-OSA
pH		
Upright	7.37 ± 0.01	7.41 ± 0.01*
Supine	7.37 ± 0.01	7.42 ± 0.01*
PaCO ₂ (mmHg)		
Upright	42.8 ± 1.0	39.7 ± 1.0**
Supine	42.9 ± 1.0	40.2 ± 1.0*
PaO ₂ (mmHg)		
Upright	79.3 ± 2.9	86.4 ± 2.9**
Supine	79.6 ± 2.5	84.3 ± 2.9

(Intergroup, *P<0.05; **P<0.005)

not significantly increase the occurrence of sawtooth-ing, therefore, having no effect on its sensitivity or specificity as a criteria for predicting OSA.

Sixteen of the 28 patients in the OSA group and 7 of the 20 patients in the non-OSA group had a maximal mid-flow rate ratio of greater than or equal to one in either the upright or supine positions. The addition of supine testing increased the sensitivity (although not significantly), with no change in specificity. Overall sensitivity and specificity for this parameter in detect-

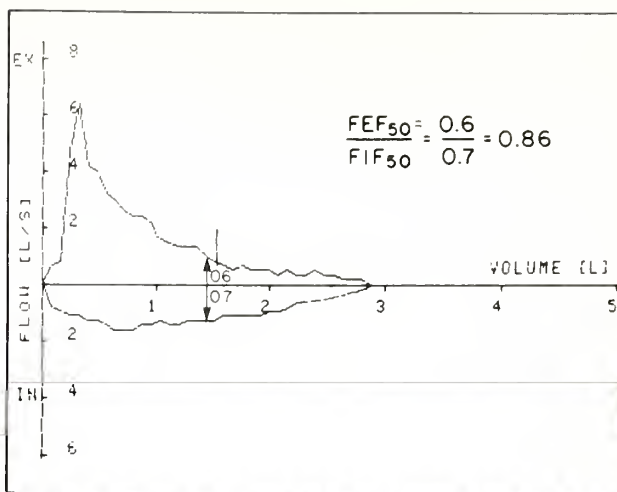


Figure 3—Flow volume curves demonstrating FEF50/FIF50.

ing an apparent critical level of upper airway patency in OSA were 57.1 percent and 65.0 percent, respectively.

Flattening of the inspiratory limb of the VVC was present in 18 of 28 OSA patients and 9 of 20 non-OSA patients. The addition of supine testing increased the sensitivity to 64.3 percent from 35.7 percent with upright testing alone. The combination of upright and supine tests did not diminish the specificity.

In the upright and supine postures, 25 of 28 patients with OSA and 11 of 20 patients in the non-OSA group demonstrated at least one of the criteria of UAO. Thus, the overall sensitivity for detecting UAO in the OSA group was 89.3 percent, and the specificity was 45 percent. The addition of supine to upright VVC testing increased the sensitivity by 21.4 percent (P<0.05) with no significant decrease in specificity. The negative predictive value for OSA utilizing all three criteria was 75.0 percent, while the positive predictive value was 69.4 percent. Of all the criteria examined, sawtooth-ing had the highest positive predictive value of 85.7 percent.

DISCUSSION

Analysis of the VVC has been shown by previous investigators^{3,6,10-15} to be a sensitive means of detecting upper airway obstruction in patients with the OSA syndrome (Table 5). The criteria used to define UAO were the presence of sawtooth-ing and a mid-maximal flow rate ratio (FEF50/FIF50) greater than or equal to one. Sawtooth-ing first was described by Sanders et al.¹⁰ and is felt to be caused by an "alteration of the pattern of airflow created by intermittent narrowing, i.e. caused by fluttering of tissue, of the upper airway." Using fiberoptic endoscopy during sleep, this fluttering was observed. Miller and Hyatt initially demonstrated the usefulness of the mid-flow rate ratio in defining narrowing of the upper airway.¹⁶ Such "variable extrathoracic obstruction" had a mean ratio of 2.2, while patients with peripheral airway narrowing had a mean ratio of 0.32 and, as previously described,¹⁷ was the result of an abnormally high transmural positive pressure gradient created across the narrowed extrathoracic airway on inspiration.

We added flattening of the inspiratory limb of the VVC to the other two criteria, since expiratory flow is

diminished to a greater extent than inspiratory flow in peripheral obstructive lung disease, decreasing the sensitivity of the FEF50/FIF50 criteria in such patients (Figure 3).¹⁶

The combined results of the previous investigators (Table 5) revealed an overall sensitivity for FEF50/FIF50 or sawtoothing of 74 percent with a range of 50 to 92 percent. A previous study reported a 21 percent increase in sensitivity, similar to our findings, when supine VVC were added to upright testing.¹⁴

In their report describing sawtoothing as a useful screening test for OSA, Sanders et al. found an overall 84.6 percent sensitivity.¹⁰ Although the sensitivity of sawtoothing in detecting UAO in OSA in our series of patients was only 42.8 percent, it remains a highly specific test for OSA (90 percent), with a high positive predictive value (85.7 percent). The sensitivity of sawtoothing alone in other reports varied from 29 to 61 percent with an overall mean of 47 percent (Table 5).

In a preliminary study, it was suggested that reflex changes in upper airway diameter as a result of mass loading of the diaphragm, decreasing the functional residual capacity, may be the pathogenesis of flattening of the inspiratory limb induced when assuming

the supine posture.¹⁸ It has been demonstrated previously that obese OSA patients have a smaller pharyngeal cross-sectional area than obese non-OSA patients.¹⁹ Furthermore, the change in lung volumes occurring from TLC to functional residual capacity (FRC) were associated with greater decreases in the pharyngeal cross-sectional area in patients with OSA, than in obese nonapneic control subjects.¹⁹ This decrease in pharyngeal size also is seen in nonobese snorers.²⁰ The decrease in cross-sectional area has been attributed to a greater "collapsibility" of the upper airway⁷ in OSA patients, as well as to a greater degree of tonic stimulation of the upper airway dilator muscles in obese non-OSA subjects.^{19,21} Our patients did not demonstrate mass loading either in the upright or supine position as reflected by the FRC.

To evaluate if changing from the upright to supine posture was associated with a decrease in lung volumes leading to narrowing of the upper airway, lung volumes also were compared in the group of patients who exhibited flattening of the inspiratory limb of the VVC "only in the supine position." These 11 patients showed no significant differences in the mean upright and supine residual volume, functional residual capacity, or total lung capacity (Table 2). Thus, mass

TABLE 4
Criteria

Criteria		Upright	Supine	Up+Sup
Sawtoothing	Sensitivity	39.3	17.9*	42.8
	Specificity	90.0	95.0	90.0
FEF50/FIF50	Sensitivity	42.9	53.6	57.1
	Specificity	65.0	70.0	65.0
Inspiratory flattening	Sensitivity	35.7*	50.0	64.3
	Specificity	65.0	55.0	55.0
All	Sensitivity	67.9*	71.4	89.3
	Specificity	50.0	45.0	45.0

(*P<0.05, comparing upright or supine to upright and supine)

TABLE 5
Previous Studies of UAO Utilizing Flow-Volume Curves

Authors	n	FEF50/FIF50	Sawtoothing	Either Criteria
Sanders	13	4 (31%)	11 (85%)	12 (92%)
Haponick	35	14 (40%)	NA	NA
Chaudharg	16	6 (38%)	9 (56%)	12 (75%)
Riley	12	NA	NA	6 (50%)
Tammelin	22	4 (22%)	8 (36%)	15 (68%)
Haponick	72	25 (35%)	36 (50%)	NA
Shore	17	7 (41%)	5 (29%)	10 (50%)
		8 (47%)	7 (41%)	11 (65%)
		9 (53%)	8 (47%)	12 (71%)
Krieger	30	20 (67%)	18 (61%)	26 (86%)
Total		87 (42%)	80 (47%)	81 (74%)

loading of the diaphragm does not appear to be the cause of flattening of the inspiratory limb upon assuming the supine position.

Patients with snoring plus OSA have significantly greater pharyngeal distensibility than non-OSA snorers.⁷ While the OSA patients, when assuming the supine posture decrease the cross-sectional area of their pharynx more so than the non-OSA snorers, it is felt that the major difference between snorers with OSA and those without OSA is an associated change in pharyngeal compliance, and that pharyngeal size alone is insufficient to convert nonapneic to apneic patients.⁷

The narrowing of the upper airway which occurs when the patients assume the supine posture as reflected in the VVC may be due to gravitational forces, without a reflexogenic component. It is due to the alleviation of this positional dependent compromise of pharyngeal size that alteration of sleep posture alone, by assuming the upright position, has been shown to effectively eliminate or significantly reduce the number of disordered breathing events in patients with OSA.²²

SUMMARY

Upright and supine VVC can be a valuable screening tool for patients with equivocal signs and symptoms of the OSA syndrome. A negative VVC is strong evidence against the presence of significant obstructive sleep apnea. Also, we have demonstrated the usefulness of sequential VVC in patients with OSA as they lose weight.²³ With weight loss, the abnormalities in the VVC characterizing UAO revert to normal, e.g. loss of sawtoothing, FEF50/FIF50 becomes less than one. Thus, the VVC serves as a guide to determine when a patient who undergoes weight loss should be restudied with an all-night polysomnogram.

REFERENCES

1. Remmers JE, DeGroot WJ, Sauerland EK, Anch AM: Pathogenesis of upper airways occlusion during sleep. *J Appl Physiol* 44:931-938, 1978.
2. Browiecki B, Pollak CP, Weitzman E: Fiberoptic study of pharyngeal airway during sleep in patients with hypersomnia sleep apnea syndrome. *Laryngoscope* 88:1310-1313, 1978.
3. Riley RW, Guilleminault C, Herran J, Powell N: Cephalometric analysis and flow-volume loops in obstructive sleep apnea. *Sleep* 6:303-311, 1983.
4. Rivlin J, Hoffstein V, Kalbfleisch J, et al: Upper airway morphology in patients with idiopathic obstructive sleep apnea. *Am Rev Respir Dis* 129:355-360, 1984.
5. Haponick EF, Smith PL, Bohlman ME, et al: Com-

puterized tomography in obstructive sleep apnea. Correlation of airway size with physiology during sleep and wakefulness. *Am Rev Respir Dis* 127:221-226, 1983.

6. Haponick EF, Bleeker ER, Allen RP, et al: Abnormal inspiratory flow-volume curves in patients with sleep disordered breathing. *Am Rev Respir Dis* 124:571-574, 1981.

7. Brown IB, McClean PA, Boucher R, et al: Changes in pharyngeal cross-sectional area with posture and application of continuous positive airway pressure in patients with obstructive sleep apnea. *Am Rev Respir Dis* 136:628-632, 1987.

8. Rechtschaffen A, Kales A: A manual of standardized terminology, techniques, and scoring system for sleep stages of human subjects. Washington, D.C., National Institute of Health, 1968 (NIH publication no. 204).

9. Onal E, Lopata M, O'Connor T: Pathogenesis of apneas in hypersomnia-sleep apnea syndrome. *Am Rev Respir Dis* 125:167-174, 1982.

10. Sanders MH, Martin RJ, Pennock BE, Rogers RM: The detection of sleep apnea in the awake patient. The 'sawtooth' sign. *JAMA* 245:2414-2418, 1981.

11. Chaudharg BA, Elguindi AS, Giacomini K, Speir WA: Diagnosis of sleep apnea by flow-volume loop. *Am Rev Respir Dis* 125:101A, 1982.

12. Tammelin BR, Wilson AF, Borowiecki B, Sassini JF: Flow-volume curves reflect pharyngeal airway abnormality in sleep apnea syndrome. *Am Rev Respir Dis* 128:712-715, 1983.

13. Haponick EF, Smith PL, Kaplan J, Bleeker ER: Flow-volume curves and sleep-disordered breathing: Therapeutic implications. *Thorax* 38:609-615, 1983.

14. Shore ET, Millman, RP: Abnormalities in the flow-volume loop in obstructive sleep apnea sitting and supine. *Thorax* 39:775-779, 1984.

15. Krieger J, Weitzenblum E, Vandvenne A, et al: Flow-volume curve abnormalities and obstructive sleep apnea syndrome. *Chest* 87:163-167, 1985.

16. Miller RD, Hyatt RE: Obstructing lesions of the larynx and trachea: Clinical and physiologic characteristics. *Mayo Clin Proc* 44:145-161, 1969.

17. Miller RD, Hyatt RE: Evaluation of obstructing lesions of the trachea and larynx by flow-volume loop. *Am Rev Respir Dis* 108:475-481, 1973.

18. Nahmias J, Fourre J, Karetzky M: Upright and supine flow volume curves in patients with obstructive sleep apnea. *Am Rev Respir Dis* 135:50A, 1987.

19. Hoffstein V, Zamal N, Phillipson EA: Lung volume dependence of pharyngeal cross-sectional area in patients with obstructive sleep apnea. *Am Rev Respir Dis* 130:175-178, 1984.

20. Bradley TD, Brown IG, Grossman RF, et al: Pharyngeal size in snorers, nonsnorers, and patients with obstructive sleep apnea. *N Engl J Med* 315:1327-1331, 1986.

21. Lopata M, Onal E: Mass loading, sleep apnea, and the pathogenesis of obesity hypoventilation. *Am Rev Respir Dis* 126:640-645, 1982.

22. Mcevoy RP, Sharp DJ, Thornton AJ: The effect of posture on obstructive sleep apnea. *Am Rev Respir Dis* 133:662-666, 1986.

23. Nahmias J, Fourre J, Karetzky M: Effect of weight loss on the upright and supine flow-volume curves, arterial blood gases, and disordered breathing events in patients with obstructive sleep apnea. *Chest* 92:67, 1987.

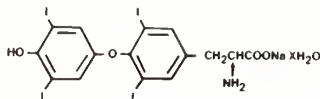
LEVOXINE®

(LEVOTHYROXINE SODIUM TABLETS, USP)

FOR ORAL ADMINISTRATION

DESCRIPTION:

Each LEVOXINE (Levothyroxine Sodium, USP) tablet contains synthetic crystalline levothyroxine sodium (L-thyroxine). L-thyroxine is the principal hormone secreted by the normal thyroid gland. Chemically, L-thyroxine is designated as L-tyrosine, O-(4-hydroxy-3, 5-diiodophenyl) - 3,5-diiodo-, monosodium salt, hydrate. The molecular formula is $C_{15}H_{10}I_4NNaO_4$ and the structural formula is:



CLINICAL PHARMACOLOGY:

The principal effect of thyroid hormones is to increase the metabolic rate of body tissues.

The thyroid hormones are also concerned with growth and development of tissues in the young.

The major thyroid hormones are L-thyroxine (T_4) and L-triiodothyronine (T_3). The amounts of T_4 and T_3 released from the normally functioning thyroid gland are regulated by the amount of thyrotropin (TSH) secreted from the anterior pituitary gland. T_4 is the major component of normal thyroid gland excretions and is therefore the primary determinant of normal thyroid functions. T_4 acts as a substrate for physiologic deiodination to T_3 in the peripheral tissues. The physiologic effects of thyroid hormones are mediated at the cellular level primarily by T_3 .

LEVOXINE (L-thyroxine) tablets taken orally provide T_4 which upon absorption can not be distinguished from T_4 that is secreted endogenously.

INDICATIONS AND USAGE:

LEVOXINE (L-thyroxine) tablets are indicated as replacement or supplemental therapy for diminished or absent thyroid function (e.g., cretinism, myxedema, nontoxic goiter or hypothyroidism generally, including the hypothyroid state in children, in pregnancy and in the elderly) resulting from functional deficiency, primary atrophy, from partial or complete absence of the gland or from the effects of surgery, radiation or antithyroid agents. Therapy must be maintained continuously to control the symptoms of hypothyroidism.

CONTRAINDICATIONS:

L-thyroxine therapy is contraindicated in thyrotoxicosis, acute myocardial infarction and uncorrected adrenal insufficiency.

WARNINGS:

Drugs with thyroid hormone activity, alone or together with other therapeutic agents, have been used for the treatment of obesity. In euthyroid patients, doses within the range of daily hormonal requirements are ineffective for weight reduction. Larger doses may produce serious or even life-threatening manifestations of toxicity, particularly when given in association with sympathomimetic amines such as those used for their anorectic effects.

PRECAUTIONS:

General — Caution must be exercised in the administration of this drug to patients with cardiovascular disease. Development of chest pains or other aggravation of the cardiovascular disease requires a reduction of dosage.

Information For The Patient — Patients on thyroid preparations and parents of children on thyroid therapy should be informed that:

1. Replacement therapy is to be taken essentially for life, with the exception of cases of transient hypothyroidism, usually associated with thyroiditis, and in those patients receiving a therapeutic trial of the drug.
2. They should immediately report during the course of therapy any signs or symptoms of thyroid hormone toxicity, e.g., chest pain, increased pulse rate, palpitations, excessive sweating, heat intolerance, nervousness, or any other unusual event.
3. In case of concomitant diabetes mellitus, the daily dosage of antidiabetic medication may need readjustment as thyroid hormone replacement is achieved. If thyroid medication is stopped, a downward readjustment of the dosage of insulin or oral hypoglycemic agent may be necessary to avoid hypoglycemia. At all times, close monitoring of urinary glucose levels is mandatory in such patients.
4. In case of concomitant oral anticoagulant therapy, the prothrombin time should be measured frequently to determine if the dosage of oral anticoagulants is to be readjusted.
5. Partial loss of hair may be experienced by children in the first few months of thyroid therapy, but this is usually a transient phenomenon and later recovery is usually the rule.

Laboratory Tests — The patient's response to thyroid replacement may be followed by laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels.

Drug Interactions — In patients with diabetes mellitus, addition of thyroid hormone therapy may cause an increase in the required dosage of insulin or oral hypoglycemic agents. Therefore, patients with diabetes mellitus should be observed closely for possible changes in antidiabetic drug dosage requirements.

Patients stabilized on oral anticoagulants who are found to require thyroid replacement therapy should be watched very closely when therapy is started. If a patient is truly hypothyroid, it is likely that a reduction in anticoagulant dosage will be required. No special precautions appear to be necessary when oral anticoagulant therapy is begun in a patient already stabilized on maintenance thyroid replacement therapy.

Cholestyramine binds both T_4 and T_3 in the intestine, thus impairing absorption of these thyroid hormones. In vitro studies indicate that the binding is not easily removed. Therefore, four to five hours should elapse between administration of cholestyramine and thyroid hormones.

Estrogens tend to increase serum thyroxine-binding globulin (TBG). In a patient with a non-functioning thyroid gland who is receiving thyroid replacement therapy, free thyroxine may be decreased when estrogens are started thus increasing thyroid requirements. However, if the patient's thyroid gland has sufficient function the decreased free thyroxine will result in a compensatory increase in thyroxine output by the thyroid. Therefore, patients without a functioning thyroid gland who are on thyroid replacement therapy may need to increase their thyroid dose if estrogens or estrogen containing oral contraceptives are given.

Drug/Laboratory Test Interactions — The following drugs or moieties are known to interfere with laboratory tests performed on patients taking thyroid hormone. Androgens, corticosteroids, estrogens, oral contraceptives containing estrogens, iodine-containing preparations, and the numerous preparations containing salicylates.

1. Changes in TBG concentration should be taken into consideration in the interpretation of T_4 and T_3 values. In such cases, the unbound (free) hormone should be measured. Pregnancy, estrogens, and estrogen-containing oral contraceptives increase TBG concentrations. TBG may also be increased during infectious hepatitis. Decreases in TBG concentrations are observed in nephrosis, acromegaly, and after androgen or corticosteroid therapy. Familial hyper- or hypo-thyroxine-binding-globulinemias have been described. The incidence of TBG deficiency approximates 1 in 9000. The binding of thyroxine by thyroid-binding prealbumin (TBPA) is inhibited by salicylates.
2. Medical or dietary iodine interferes with all in vivo tests of radio-iodine uptake, producing low uptakes which may not be reflective of a true decrease in hormone synthesis.
3. The persistence of clinical and laboratory evidence of hypothyroidism in spite of adequate dosage replacement indicates either poor patient compliance, poor absorption, excessive fecal loss, or inactivity of the preparation. Intracellular resistance to thyroid hormone is quite rare.

Carcinogenesis, Mutagenesis, And Impairment Of Fertility

— A reportedly apparent association between prolonged thyroid therapy and breast cancer has not been confirmed and patients on thyroid for established indications should not discontinue therapy. No confirmatory long-term studies in animals have been performed to evaluate carcinogenic potential, mutagenicity, or impairment of fertility in either males or females.

Pregnancy — Category A — Thyroid hormones do not readily cross the placental barrier. The clinical experience to date does not indicate any adverse effect on fetuses when thyroid hormones are administered to pregnant women. On the basis of current knowledge, thyroid replacement therapy to hypothyroid women should not be discontinued during pregnancy.

Nursing Mothers — Minimal amounts of thyroid hormones are excreted in human milk. Thyroid is not associated with serious adverse reactions and does not have a known tumorigenic potential. However, caution should be exercised when thyroid is administered to a nursing woman.

Pediatric Use — Pregnant mothers provide little or no thyroid hormone to the fetus. The incidence of congenital hypothyroidism is relatively high (14,000) and the hypothyroid fetus would not derive any benefit from the small amounts of hormone crossing the placental barrier. Routine determinations of serum (T_4) and/or TSH is strongly advised in neonates in view of the deleterious effects of thyroid deficiency on growth and development.

Treatment should be initiated immediately upon diagnosis, and maintained for life, unless transient hypothyroidism is suspected, in which case, therapy may be interrupted for 2 to 8 weeks after the age of 3 years to reassess the condition. Cessation of therapy is justified in patients who have maintained a normal TSH during those 2 to 8 weeks.

ADVERSE REACTIONS:

Adverse reactions are due to overdosage and are those of induced hyperthyroidism.

OVERDOSAGE — Excessive dosage of thyroid medication may result in symptoms of hyperthyroidism. Since, however, the effects do not appear at once, the symptoms may not appear for one to three weeks after the dosage regimen is begun. The most common signs and symptoms of overdosage are weight loss, palpitation, nervousness, diarrhea or abdominal cramps, sweating, tachycardia, cardiac arrhythmias, angina pectoris, tremors, headache, insomnia, intolerance to heat and fever. If symptoms of overdosage appear, discontinue medication for several days and reinstitute treatment at a lower dosage level.

Laboratory tests such as serum T_4 , serum T_3 and the free thyroxine index will be elevated during the period of overdosage.

Complications as a result of the induced hypermetabolic state may include cardiac failure and death due to arrhythmia or failure.

TREATMENT OF OVERDOSAGE — Dosage should be reduced or therapy temporarily discontinued if signs and symptoms of overdosage appear. Treatment may be reinstituted at a lower dosage. In normal individuals, normal hypothalamic-pituitary-thyroid axis function is restored in 6 to 8 weeks after thyroid suppression.

Treatment of acute massive thyroid hormone overdosage is aimed at reducing gastrointestinal absorption of the drugs and counteracting central and peripheral effects, mainly those of increased sympathetic activity. Vomiting may be induced initially if further gastrointestinal absorption can reasonably be prevented and barring contraindications such as coma, convulsions, or loss of the gagging reflex. Treatment is symptomatic and supportive. Oxygen may be administered and ventilation maintained. Cardiac glycosides may be indicated if congestive heart failure develops. Measures to control fever, hypoglycemia, or fluid loss should be instituted if needed. Antiadrenergic agents, particularly propranolol, have been used advantageously in the treatment of increased sympathetic activity. Propranolol may be administered intravenously at a dosage of 1 to 3 mg over a 10 minute period or orally, 80 to 160 mg/day, especially when no contraindications exist for its use.

DOSAGE AND ADMINISTRATION:

The goal of therapy should be the restoration of euthyroidism as judged by clinical response and confirmed by appropriate laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels. The age and general condition of the patient and the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage.

In otherwise healthy adults, the recommended initial dose is 25 to 100 mcg (0.025 to 0.1 mg) daily, while the predicted full maintenance dose of 100 to 200 mcg (0.1 to 0.2 mg) daily may be achieved in two to three weeks.

In the elderly patient with long standing disease, evidence of myxedema, or evidence of cardiovascular dysfunction, the initial dose may be as little as 12½ mcg (0.0125 mg) per day. Incremental increases of 25 mcg (0.025 mg) per day at 3 to 4 week intervals may be instituted depending on patient response. It is the physician's judgement of the severity of the disease and close observation of patient response which determine the rate and extent of dosage increase.

In infants and children there is a great urgency to achieve full thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult. The recommended daily replacement dosage of L-thyroxine in childhood is: 0-1 years: 5-6 mcg/kg; 1-5 years: 3-5 mcg/kg; 6-12 years: 4-5 mcg/kg of body weight daily.

DOSAGE FORMS AVAILABLE:

LEVOXINE (L-thyroxine) tablets are supplied as oval, color coded, potency marked tablets in eleven strengths: 12½ mcg (0.0125 mg)—maroon, 25mcg (0.025 mg)—orange, 50 mcg (0.05 mg)—white, 75 mcg (0.075 mg)—purple, 100 mcg (0.1 mg)—yellow, 112 mcg (0.112 mg)—rose, 125 mcg (0.125 mg)—brown, 150 mcg (0.15 mg)—blue, 175 mcg (0.175 mg)—turquoise, 200 mcg (0.2 mg)—pink and 300 mcg (0.3 mg)—green, in bottles of 100, 1000, unit dose cartons of 100 (10 strips of 10 each), and 500 mcg injectable (See injectable package insert).

dp DANIELS
PHARMACEUTICALS, INC.

2517 25th Avenue North
St. Petersburg, Florida 33713-3999

A PHYSICIAN'S DUTY TO DISCLOSE THAT HIS PATIENT HAS AIDS

GARY D. NISSENBAUM, J.D., NEWARK*

This paper answers the question: How should a physician balance conflicting legal obligations to maintain confidentiality of an AIDS/ARC or HIV-infected patient, against the physician's duty to warn unsuspecting third parties of possible infection?

Here is a partial summary of a recent storyline for the television soap opera, "The Young and the Restless": Scott has Jessica tested for AIDS. The patient's pneumonia is AIDS-related, Scott discovers—no wonder she hasn't responded to treatment. Jessica's medication is changed. Now all they can do is hope for the best. When Jessica regains consciousness and discovers the doctors know she has AIDS, she's scared Cricket or John will find out. She pleads with Scott not to tell them, then slips back into an unconscious state.¹

We all can predict the forthcoming storyline: Scott will call his lawyer to determine whether he has a duty to breach Jessica's confidence and disclose her condition to known third parties who may contract the virus from her. Whatever Scott ultimately does, the savvy viewer knows the outcome—a ratings blockbuster involving an extended courtroom battle for breaching Jessica's confidence or for failing to breach it. Stay tuned.

If this dilemma has made it to our national forum of vicarious tragedy, the soap opera, can the real-life courtroom dramas be far behind? In fact, given the alarming rise of diagnosed AIDS/ARC and HIV infection in the general population, it is amazing that there has been such a dearth of lawsuits for failure to warn third parties who may risk exposure.²

The potential is there. For example, in the January

29, 1987, *Wall Street Journal*, Marilyn Chase reported the story of a very religious AIDS patient, now divorced, who secretly is a bisexual. His wife is remarried and contemplating pregnancy, but is not aware that she may have been exposed to the AIDS virus. A physician familiar with the case stated, "I say he's got a responsibility to warn her. He says it's too devastating because it will compromise his secret." Chase also wrote of a bisexual patient who refuses to use a condom with his girlfriend since it will "tip her off that something has changed about him."

The dilemma for the physician is that the experts disagree on the extent of, or even the existence of, the duty to warn third parties. One treatise asks, "Does the physician have a duty to notify the spouse [of someone who tests positive for HIV infection] directly? Probably not, provided the physician stresses the importance of the patient notifying the noninfected spouse."³ A second commentator stated: "Based on general principles, the physician has both legal and ethical duties to warn the patient's spouse. Nevertheless, although this response is rational and comforting to some, it should not be accepted as universally authoritative."⁴ Finally, a third commentator took the position that although

*Mr. Nissenbaum is an attorney with Saiber, Schlesinger, Satz & Goldstein. Correspondence may be addressed to Mr. Nissenbaum, Saiber, Schlesinger, Satz & Goldstein, One Gateway Center, Newark, NJ 07102.

a physician has a duty to warn the patient's spouse, "that duty would be fulfilled by reporting the patient's recalcitrance to the public health authorities, who have the responsibility for notifying contacts and other epidemiologic tasks."⁵

The purpose of this article is to clarify that issue, taking into account the dictates of the New Jersey common law, statutes, and administrative code.⁶

PHYSICIANS' DUTY TO DISCLOSE

According to the fourth principle of medical ethics of the American Medical Association "[A] physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law." Section 5.05 elaborates upon this exhortation: "The obligation to safeguard patient confidences is subject to certain exceptions which are ethically and legally justified because of overriding social considerations. Where a patient threatens to inflict serious bodily harm to another person and there is reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities."

Thus, the American Medical Association expressly recognizes exceptions to the general proscriptions against disclosure set forth in the Hippocratic oath to which each physician expressly binds himself: "Whatever in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret."⁷

Every New Jersey physician attending any person ill with AIDS or ARC must report the disease in writing to the New Jersey State Department of Health (DOH)⁸ within 12 hours of the diagnosis.⁹ The information is to be kept strictly confidential by the DOH and is not subject to public inspection.¹⁰

Furthermore, the New Jersey legislature recently enacted a law requiring physicians and certain others to disclose to funeral directors when a deceased person who had AIDS/ARC, HIV infection, or certain other diseases, has been sent to them for handling and disposition of the body.¹¹

As a practical matter, given the exigencies and time constraints of a busy medical practice, it may be quite useful for a physician to refer his patient to a DOH counseling center for followup contact tracing and notification. DOH counselors will speak directly with the patient who tests positive for HIV antibodies: to provide psychological counseling and referral to support groups; to provide information regarding the disease and appropriate lifestyle changes which must be made; and to encourage cooperation with the DOH contact tracing program so that persons with whom the patient shared needles or engaged in other high-risk behavior can be informed they should be tested. An excellent outline of this program, as well as other vital information concerning pre- and post-test counseling and followup, can be obtained from the Department of Health in its 1988 draft report entitled, *A Physician's Guide to HIV Antibody Counseling and Testing*.

Confidentiality is the lynchpin of the program. Patients are assured that the DOH will not disclose their names to the persons whom they may have exposed to the disease. Instead, the DOH counselor will inform third parties they may have been exposed to the disease and should be tested. If an individual enters a counseling and testing site location for a blood test, he automatically will receive pre- and post-test counseling as well as contact tracing followup. The telephone number of the DOH, Division of AIDS, Counseling/Testing Notification Assistance Program is 609/984-6125. Information on the notification assistance program can be obtained at 1/800/367-6543. The DOH also maintains an AIDS hotline at 1/800/624-2377.

However, this may not entirely relieve the physician of his responsibility to third parties who later may become infected by the patient. The most common scenario would involve an uncooperative patient who simply refuses to allow the physician or DOH to disclose to those with whom he engaged in high-risk behavior, such as sexual intercourse or sharing hypodermic needles, that he has AIDS/ARC or HIV infection. It can be argued that if the physician knows the identities of these people, his obligation to warn them remains.

But what about the countervailing duty of confidentiality between physician and patient? The New Jersey statutes set forth a privilege for communications between a patient and physician which is operative solely when a witness is testifying in connection with a court proceeding.¹² However, our judiciary has recognized a duty on the part of a physician to maintain the secrecy of confidential information conveyed to him by his patient in nontestimonial settings as well.¹³ The aim of the common law proscription against nontestimonial disclosures limits the "right to promiscuously disclose such information ... [or] the right to gossip about a patient's health." However, the nontestimonial physician/patient duty of confidentiality is not an absolute right, "but rather ... a limited right against such disclosure, subject to exceptions prompted by the supervening interest of society."¹⁴

Those exceptions can create a duty such as that established by *Tarasoff versus Regents of University of California*.¹⁵ In that case, the daughter of the plaintiff was murdered by a psychiatric patient. The plaintiff sued the psychotherapist, among others, under a theory that, since the therapist either determined, or should have determined, the patient presented a serious danger to a specific person, the therapist had an obligation to use reasonable care to protect the intended victim against that danger. The duty to breach the patient confidence was limited to that necessary to protect the victim. "(T)he therapist's obligations to his patient require that he not disclose a confidence unless such disclosure is necessary to avert danger to others, and even then that he do so discreetly, and in a fashion that would preserve the privacy of his patient to the fullest extent compatible with the prevention of the threatened danger."¹⁶

This doctrine was the basis for the holding in the New Jersey case of *MacIntosh versus Milano*.¹⁷ In that case a wrongful-death action was brought against a psychiatrist because one of his patients murdered the

plaintiff's daughter. The court held that the psychiatrist has a duty to disclose to the daughter that she was the intended victim of his patient if he knew, or should have known, that information: "[A] psychiatrist or therapist may have a duty to take whatever steps are reasonably necessary to protect an intended or potential victim of his patient when he determines, or should determine, in the appropriate factual setting and in accordance with the standards of his profession established at trial, that the patient is or may present a probability of danger to that person." The MacIntosh court related this duty to "the more broadly based obligation a practitioner may have to protect the welfare of the community, which is analogous to the obligation a physician has, to warn third persons of infectious or contagious disease."¹⁸

The MacIntosh principle is related to a physician's duty to inform immediate family members of a patient's diagnosis in instances when they might be damaged by a lack of that information. In the New Jersey Supreme Court case of *Shroeder versus Perkel*,¹⁹ a suit was brought against a physician for, among other things, failing to disclose to the parents that their child had been born with cystic fibrosis, with the result they unknowingly conceived a second child with cystic fibrosis. The court held that "(A) physician's duty thus may extend beyond the interests of a patient to members of the immediate family of the patient who may be adversely affected by a breach of that duty." In the New York case of *Curry versus Corn*,²⁰ the court held that a physician cannot be sued for disclosing to a spouse of a patient that the patient had a disease because "(a)s a prospective husband or wife is entitled to know before marriage whether his or her future spouse is suffering from a diseased condition, it would appear to follow that during marriage each has the right to know the existence of any disease which may have bearing on the marital relation."

CONCLUSION

If a patient refuses to disclose that he has AIDS/ARC or HIV infection to those with whom he has shared, or may share in the future, bodily fluids, the physician should seek the assistance of the Department of Health to counsel the patient. In the extreme case where counseling has failed, although there is some legal risk, the physician probably can inform third parties who will likely be harmed by the patient due to the sharing of bodily fluids.

Areas of grey remain, however. For example, is it reasonable for a physician to take his patient's word that the patient will disclose to those third parties? Does the physician have the duty of following up to make sure that, when the patient discloses contacts he has had, he has given a complete list? What if the

physician ascertains that the individual is engaging in irresponsible behavior, but the physician obtains this information from a source which may not be reliable, and the patient denies it? How long may the physician wait for the patient to change his mind regarding a refusal to cooperate with contact tracing efforts?

Although these issues have not been resolved as yet, litigation by exposed third parties, and the concomitant guidance by the courts, is on its way. In the interim, physicians must carefully evaluate the equities of the dilemma. Under certain circumstances a disclosure to a spouse or "significant other" may carry far less legal risk and severity to the attending physician than a suit by an infected third party for breach of the duty of confidentiality.

REFERENCES

1. *Soap Opera Digest*, July 26, 1988.
2. Wofsy, Kaplan, Volberding: Clinical and Laboratory Features of HIV Infection, from the National Academy of Sciences, 1987.
3. Dornette HL: *AIDS And The Law*, at 252, 253 (1987).
4. Goldberg BA: AIDS and patient confidentiality: More dilemmas for physicians and lawyers. *Consultant Magazine*, Oct. 1987.
5. Mills, Wofsy, Mills: The acquired immunodeficiency syndrome. *N Engl J Med* 933, 1986.
6. Other states such as New York and California have passed statutes setting forth requirements concerning this duty to disclose that an individual has AIDS to endangered third parties as it relates to the duty to protect confidentiality. 1988 N.Y. Laws, Ch. 584, Art. 27-F, Sec. 2780, et seq.; 1988 Cal. Legis. Serv. 1216 (West). There are a number of bills presently pending in the New Jersey legislature which if passed will impact upon this issue. As of this writing, none of the bills are finalized and they have not been included in this article.
7. Recently, the AMA proposed model legislation, not yet adopted in New Jersey, which would, among other things, allow disclosure of "[a]ny information and records" containing identifying information regarding a person who is or may be, AIDS infected or HIV positive in a number of settings, including when the health care provider reasonably believes that disclosure "will avoid or minimize an imminent danger to the health or safety of the patient or of any other individual." *Model Act To Provide for AIDS Confidentiality, Reporting, and Partner Notification* (AMA, Dept. of State Leg., Div. of Leg. Activities, 1987).
8. N.J.A.C. 8:57-1.14(c)(1).
9. N.J.S.A. 26:4-15.
10. N.J.A.C. 8:57-1.14(f).
11. 1988 N.J. Sess. Law Serv. 684 (West).
12. N.J.S.A. 2A:84A-22.1 and 22.2.
13. *Stempler v. Speidell*, 100 N.J. 368, 377 (1985).
14. *Hague v. Williams*, 37 N.J. 328, 335, 336 (1962).
15. 131 Cal. Rptr. 14, 551 P.2d 334 (1976).
16. *Id.* at 347.
17. 168 N.J. super. 466 (Law Div. 1979).
18. *Id.* at 489, 490.
19. 87 N.J. 53, 65 (1981).
20. 52 Misc. 2d 1035, 277 N.Y.S. 2d 470, 471 (Sup. Ct. 1966).

When it comes to your patients' health leave no stone unturned.



Lithotripsy at The New Jersey Kidney Stone Treatment Center can be the alternative.

Convenience—The New Jersey Kidney Stone Treatment Center is centrally located in downtown New Brunswick, near major highways, for easy access for you and your patients.

Flexible scheduling—The Center offers scheduling with no delay. In most cases, your patient can be treated within a week of your call. Our extended hours allow you to make appointments at the convenience of both you and your patients.

Bath-free equipment—The Center is equipped with the most advanced Dornier HM4 lithotripter, eliminating the need for a water bath, allowing for easier patient handling and greater patient comfort. Also in use is a state-of-the-art Shimazdu Hydrojust III cystoscopy table.

Experienced, professional staff—The staff of the New Jersey Kidney Stone Treatment Center is well-versed in lithotripsy treatment, and includes board-certified Anesthesiologists, critical-care trained nurses and skilled lithotripsy technicians.

Physician billing—Urologists treating patients at the Center have the advantage of billing their patients or third-party payers directly through their own offices.

Easy referral system—If desired, physicians can easily refer their patients to one of our staff Urologists for lithotripsy treatment.

HMO eligibility—The Center has established arrangements with most major area HMO's.

For more information regarding how the Center can help you and your kidney stone patients, call 1-800-542-8887 or (201) 937-8614.

New Jersey Kidney Stone Treatment Center

**Located at Robert Wood Johnson University Hospital
New Brunswick, New Jersey 1-800-542-8887**

The New Jersey Kidney Stone Treatment Center is operated by Health Horizons (ESWL), L.P., affiliated with the following hospitals: Community Memorial Hospital, Freehold Area Hospital, Helene Fuld Medical Center, Jersey Shore Medical Center, Raritan Bay Medical Center, Riverview Medical Center, Robert Wood Johnson University Hospital, St. Francis Medical Center, St. Peter's Medical Center, Somerset Medical Center.

COMMENTARY: PHYSICIAN PEER REVIEW IN NEW JERSEY

WILLIAM A. DWYER, JR., M.D., FAIR LAWN*

An analysis of the current status of physician-controlled review of medical care in New Jersey is presented. Given the present muddled status of peer review, suggestions for meaningful reform are outlined.

Since the time of Hippocrates, physicians have maintained an interest in the quality and the results of the professional care they render patients. This perspective has not always redounded to the patients' benefit, particularly when innovative technology has impacted on traditional methods of medical practice.

History is replete with examples of resistance to change, even in this modern era. These examples range from the simple to the highly technical, including: the unwillingness to accept handwashing as a way of preventing puerperal fever in the 19th century, the resistance to the concept of appendicitis as a disease and of the requirement of surgical intervention for its relief, the lack of willingness to investigate the impact of nutrition, and fluid balance in sick or injured patients.

In some ways, these are indictments of the medical profession. However, it must be kept in mind that the profession is a collection of human beings who have worked hard to master their craft and who, utilizing that hard-earned knowledge, do manage to improve the status of most of their patients. Because medicine is an imprecise science and no two patients (identical twins excepted) are alike, it is very difficult to sort out what will and what will not work for the individual patient. These two facts make physicians very con-

servative in their adoption of "new" methodologies.

As medicine has progressed in its capacities, so too have the various methodologies for evaluating various patient treatment strategies, techniques, and drugs. The medical literature abounds with numerous studies and statistical analyses. However, no individual practitioner in private practice is likely to be willing to subject his patients to an "experimental" type of treatment; a physician's function is the utilization of professional skill and knowledge to improve or maintain the patient in as optimal a state of good health as possible.

This pragmatic approach to private practice was, and is, a necessity. However, it can and, in some rare instances, does lead to abuse either from lack of knowledge or from carelessness. In even rarer instances, fraudulent practices occur.

Society has grown increasingly concerned about this potential for abuse. At the same time, medical technology has widened its scientific base so that it is difficult to explain the nuances of many present treatments to the average layman. The ongoing debate about the employment of cardiopulmonary resuscitation in all cases, regardless of the presence of other disease, is only one major case in point.

*Correspondence may be addressed to Dr. Dwyer, 17-15 Maple Avenue, Fair Lawn, NJ 07410-1514.

The increase in malpractice suits is a natural outgrowth of the many misunderstandings and misconceptions that have arisen as a direct result of this rapidly expanding technology.

In 1972, the federal government expressed this concern in the form of a review program designed to provide some assurance that federal monies were being expended for medically necessary care that met reasonable practice standards; when enacting the program, congressmen stated this was the purpose of the legislation.

Unfortunately, the bureaucratic element in government immediately interpreted this program as a cost-cutting measure and had no interest in these dual purposes.

The program was created by local physicians who would develop criteria to review federally financed (Medicare and Medicaid) cases for quality of care, necessity of admission, and length of stay of the patient.

Congressional financing was provided in 1974 for the creation of 203 local review organizations. By 1975, 40 review organizations had been approved and were functioning. Over time, 201 organizations were established.

In New Jersey, the first approved organization was Passaic Valley PSRO which was in operation in late 1975. At the outset, only Medicare cases were reviewed, as the Medicaid agency in New Jersey resisted all efforts to implement the program. Only after several acrimonious meetings with then director Reilly, was it possible to bring this agency into compliance with federal law, two years after program implementation. The strong selling point for the state was the potential for cost-savings, not the benefit to the patient in the delivery of good quality medical care.

In 1975, the Congressional Budget Office released a study which demonstrated that the PSRO program, despite the expenditure of \$40 million, had demonstrated no impact on costs of medical care.

At that time, three of the eight authorized PSROs in New Jersey were functioning with limited staff. The largest costs for the program were those associated with the creation of a computer-oriented database and the construction of a methodology to obtain usable analysis. Data from the various hospitals was not timely and lagged behind actual patient admission dates by as much as a year. Additionally, the error rate in what was submitted was 30 percent.

For the next several years, the PSRO program was recommended for zero-funding by federal budget officials at Health and Human Services, despite increasing signs of effectiveness. As an example, hospital length of stay over the first five years of the program dropped from an average of 15 days to 11.5 days; the number of admissions did rise, but was commensurate with the increasing Medicare beneficiaries in the population as a whole. A calculated estimate of indirect cost savings indicated that without the impact of the PSRO program, a wave of hospital construction would have been necessary to accommodate the numbers of extra patients. In the Passaic Valley PSRO area, this estimate indicated that two additional 300-bed hospitals would have been required.

In spite of bureaucratic recommendations to the

contrary, Congress saw fit to provide funding for the program, and it continued. Deficits were underwritten by physicians working without reimbursement for time given to the peer review process.

Throughout this period, federal regulations regarding the program constantly were undergoing change, frequently without regard to the burdens of these changes on the limited financing provided.

In the early 1980s, Joann Finley, then commissioner of health, implemented the DRG program. As a condition of participation in this program, the federal government insisted on a peer review program that encompassed all patients. The repetitive assertion, through the years of PSRO review, had been that the savings demonstrated by this program were achieved by shifting costs to the private sector. Since the federal sector would be paying the same DRG rate as the private sector, the bureaucracy decided to ensure that private as well as federally financed patient care should be subject to the same conditions. The New Jersey PSROs recognized this decision as a backhanded compliment.

Under this stimulus and with the active participation of the eight PSROs, the New Jersey State Department of Health (NJDOH) created a peer review program similar to the federal model. Like the federal model, it provided that hospital payment could be denied where unnecessary admissions or days of stay were found by the review organizations. Unlike the federal model, however, it provided no mechanism for the review organization to deal with problems of the quality of care beyond referring the matter to the local hospital's quality assurance committee and bringing the power of moral suasion to bear. Both tactics were employed with limited success by the various PSROs in the state.

The prime usefulness of the review process, from the standpoint of NJDOH, was a foil for patients and insurance companies who felt they were being overcharged. These complaints were routed through the state peer review program's appeals process. The direction of determinations was by regulations which changed about twice a year, sometimes at cross purposes with previous regulations.

By 1983, in New Jersey, an all-patient review system was in place, consisting of two parts: one part subject to federal regulation and one part subject to state regulation. The system was responsible to three bureaucracies: New Jersey State Department of Health, New Jersey Medicaid, and the federal bureaucracy at HCFA. Neither of the state agencies expressed much curiosity about the program's impacts or its influences on the quality of patient care.

About this time, the New Jersey Medicaid agency estimated their savings at almost \$60 million as a result of the peer review program. The Congressional Budget Office also conducted a study and determined that the peer review program (PSRO) had saved the federal government \$25 million over and above the costs of the program, and, if left intact, probably would save \$50 million in the following year.

HCFA decided a new approach to peer review was needed that was less costly, and advocated doing away with the program entirely, leaving it to the insurance companies to carry on review of claims.

CURRENT STATUS

All patient care in New Jersey hospitals is subject to physician-controlled peer review carried out through the auspices of so-called utilization review organizations authorized and supervised by NJDOH and/or by the Health Care Financing Administration (HCFA) representing the federal government. (Medicaid review is subject to HCFA and to the New Jersey Medicaid bureaucracy.)

This is not a uniform review system, but, rather, three distinctly different review systems which reflect differing biases and objectives of the state and federal governments.

The state system was grafted to the old PSRO program and adopted its format of concurrent review of admitted cases. It reviews for necessity of admission and lengths of stay to ensure that patients need to be admitted and that no patient overstays the trim points for the various DRGs. It provides additional review to ensure that the proper diagnostic numerical codes are used for each patient chart so that the appropriate DRG group can be determined. It also has some authority to comment on the quality of care it finds, but is largely dependent on referral of discovered problems to hospital quality assurance committees in the hope that they will institute corrective action. No legal authority for followup on these quality of care matters is provided. This system does provide a two-tiered appeals mechanism for appeals by patients and physicians for length of stay denials and for hospitals, fiscal intermediaries, and patients on DRG assignments in New Jersey.

The reimbursement rates for utilization review for this system were originally determined in 1981. They have been adjusted upward in 1988 by approximately one dollar per case.

The other system is sponsored by the federal government and is applicable to the Medicare patient population. This system is based on a retrospective review of patient hospital charts; this sample encompasses 35 percent of all Medicare admissions. The sample is constructed by a random selection of 5 percent of all admissions, a review of all charts in various DRGs determined by previous statistical analyses to be a variant from national norms for individual hospitals, 100 percent of all deaths, and DRG outliers.

Additionally, any physician on intensified review (determined by findings of variation from practice norms by a physician committee) will have all his charts included for a period of time as will any institution found to have premature discharges.

These charts are reviewed for admission, possibility of premature discharge, and for quality care according to a predetermined set of screening criteria which have been developed jointly by HCFA and the AMPRA (the national physician peer review group). Where potential quality assurance problems are found, the treating physician is contacted for his comments, the case is reviewed by the PRO medical director and a specialist, and then reviewed by the PRO quality assurance committee. This latter group can invoke a variety of actions depending on the severity of the perceived problem as well as the physician's previous record, if any, of quality variation. These range from recommendation of educational enrichment to the finding of a gross and

flagrant violation which is referred further for sanction action. It also provides review for validation purposes of DRG assignment.

This system does have a single-tiered appeal mechanism for denials of admission and length of stay available to physicians and patients, but not to fiscal intermediaries or to hospitals.

This review system is funded by a contract negotiated between PRO of New Jersey and HCFA. The latter insists on funding the program on the basis of 25 percent of the caseload; does not provide contingency funds to allow for unforeseen increases in review, e.g. the sudden development of a situation where 100 percent of a hospital's Medicare cases require review because of premature discharges; and constantly has demanded increases in the scope of work performed without providing funds to cover such work increases.

The system is badly underfunded. To make matters worse, there are guidelines established for PRO performance which target improvements in various deficiencies noted by DRG. The net result of all this is to cast the PRO system into a situation where it virtually is forced into doing little investigation into controversial areas of care and having to spend more time denying admissions and lengths of stay, with a minimal impact on quality of care as a result. The capacity to engage in educational efforts for deficiencies uncovered is virtually nonexistent.

Medicaid patients in New Jersey hospitals also are subject to review by PRO. However, the Medicaid agency developed its own review program, thus introducing a third review system into the New Jersey scene. This program was structured as a retrospective one and focused on the appropriateness of patient admissions and length of stay. Additionally, it reviewed the appropriateness of the level of care rendered to the patient (acute, skilled, ICF, or custodial), and reviewed the appropriateness of mobile intensive care services rendered, together with a 15 percent sample of emergency room cases to determine whether or not these were truly emergencies. There was no attempt to outline any component of this latter program which would impact on quality.

This program was to have been implemented in October 1984. Because of numerous indecisions and vacillations at the Medicaid agency, it was not available until May 1985. The old concurrent review system applied to Medicaid patients until fall 1985, when the third system finally was implemented.

The first contract was adequate for the work outlined. However, the Medicaid agency felt that it was too generous since, in their minds, no review took place until fall 1985. This has led to a sea of confusion at this agency and they tried to write a new contract that would start in fall 1986. Medicaid review continued on the new retrospective system until March 1987, but could not be continued because payment stopped. Presently, no review is being done and no contract has been signed.

Despite its violation of federal regulations, the Medicaid agency has not been cited by the federal government. The bills it owes to the various review organizations have been unpaid and are the subject of developing litigation. NJDOH has become involved actively because state laws have been violated.

New Jersey has three review systems: one system is not funded and is in a state of chaos; the other two systems are underfunded and focus on economic outcomes, emphasizing appropriateness of admission and length of stay. While the Medicare system does pay attention to the quality of care, it does not provide for adequate funding to pursue these problems in anything like an orderly, detailed manner. Indeed, the funding of the entire Medicare review system is adequate only for a skeletonized staff and barebones review. The state's review system has provision for referral to hospital quality assurance committees, an appropriate starting point for such problems, but no provision for follow-through mechanisms. The funding level, while adequate on paper, divides the available monies between hospitals and the review systems with further undercutting of the review system's ability to carry out needed investigative programs.

Finally, none of these programs has any idea of incorporating data analysis into the review system's daily operations. Even the Medicare program relies heavily on chance discovery of a problem by passing charts through a screen of criteria.

It is conceivable that knowledgeable statisticians could produce meaningful analysis of patient data. This particularly would apply to outcome analysis. However, meaningful outcome data would necessarily depend on good physician input.

It must be remembered that our payment is being measured by DRG groups. HCFA also is conducting its quality analyses in terms of DRG groupings, since they are easy to collect. Regrettably, these are not diagnoses, but, rather, collections of different diagnoses whose similarities lie in consumptions of resources at various hospitals. Experience with such analysis quickly demonstrates that it is impossible to use them to determine the clinical significance of anything. Even used as an outcome measure as HCFA is doing with mortality rates, this probably is a badly flawed methodology.

The only analyses that can provide real information are those based on diagnosis-specific entities. Passaic Valley PSROs experience in this area led to the breakdown of the DRG group into diagnoses which were tied to the various cost centers developed by the DRG program. Even then, chart analysis was necessary for

New Jersey has three review systems: one system is not funded and is in a state of chaos; the other two systems are underfunded and focus on economic outcomes, emphasizing appropriateness of admission and length of stay.

What exists is a peer review program composed of three different systems of review of patient care, only one of which has any significant emphasis on quality of care rendered. This latter system is so badly underfunded that it can have only a very limited impact on quality. All systems are geared to economic objectives and have not begun to form a reliable database against which treatment modalities could be judged.

**VALUE OF A PHYSICIAN-CONTROLLED
PEER REVIEW SYSTEM**

The old PSRO program did achieve some noteworthy successes, utilizing standards developed by local physicians. The expansion of the program to statewide organizations lost this flavor, and the argument about the differences between rural and urban medicine is only one visible result of this loss. It still is possible to achieve this local input and this should be encouraged.

Over the past 14 years, physicians have struggled with the problem of providing review for the Medicare program, despite the efforts to do away with PROs. Through the years, review groups continually have fought to bring the matter of quality of care to the foreground of bureaucratic attention and still are trying. These efforts have resulted in some impact on patient care—patient charts have better histories and physicals, and physicians give more thought to discharge planning. Given the track record outlined in the first section, such a program does have merit even if judged on economic grounds. With improvements, it could have significant impact on patient care.

physicians to determine the significance of the variables encountered and whether or not they were meaningful in terms of patient outcome.

The need for eventual physician input exists. One further example should suffice. According to the General Accounting Office, approximately 15 percent of Medicare dollars is being spent for patients in intensive care settings. This agency contends that one-fourth of these admissions are inappropriate, including brain dead patients and patients whose complex of diseases is so severe that no human intervention has any reasonable chance of reversing the outcome. The existence of such patients and the inappropriateness of their treatment is known to the practicing physician. However, he is caught in the conflicting demands of his training, the ever-present threat of malpractice suits, and patients' families demand that everything possible must be done. He also is aware of the frequent need to house patients needing intensive care in the emergency room until an intensive care bed becomes available.

It is obvious that decisions will be needed regarding admission to intensive care units (ICU); such decisions can be developed by knowledgeable physicians, so as to indicate the type of patient that might be eligible. Alternatively, decisions can be developed by laymen, working with statistical analyses, who would apply retrospective payment denials to patients in the ICU setting with what was determined to be diagnoses in which an unacceptably low level of positive outcome is known.

Both methods would yield cost savings, but the first

method would consider properly the enormous individual variations that exist in this situation.

SUGGESTED IMPROVEMENTS IN THE NEW JERSEY PEER REVIEW SYSTEM

Three separate, economically oriented review programs currently are authorized in New Jersey for purposes of patient review. One of these systems (Medicaid) has not functioned for the past nine months.

The medical profession has not been consulted in any major way as to its conception of a patient review system that will address society's overall concerns: patient care of good quality, the delivery of this type of care at the lowest possible cost, and an accessible health care system that addresses all of a patient's health care needs.

As a whole, the medical profession has come to the realization that good quality care is the most cost-effective care; poor quality care is characterized by complications and expensive readmissions.

At present, the various bureaucracies are engaged in bargain hunting. The approach used is the limitation of access to health care through denial of various services, e.g. no assistant at a cataract operation.

The net results of all these limitations are the creation of emergency, life-threatening health care situations which always are more expensive and which frequently are fraught with multiple complications further adding to the expense.

The basic coverage currently accepted by the population of the United States (and New Jersey) is for payment of health care benefits for acute care services. The review necessary to ensure the best use of health dollars under such coverage seem relatively simple to create and easy to maintain and monitor.

Five elements are necessary:

a) An equitable mechanism whereby the quality of care rendered to patients can be reviewed and through which any perceived necessary improvements can be effectuated. Preferably, this mechanism would be locally based as defined by groupings of doctors and hospitals within reasonable geographic (or traveling time) distance.

b) An even-handed review of all patient admissions for the necessity for hospital inpatient admission to receive acute care and for the necessity of continuing to stay in the hospital to receive acute care.

c) The creation of a database which interacts with these elements to substantiate findings and perceived problems.

d) The existence of a fair, even-handed, and accessible appeals mechanism for decisions rendered in the first two elements allowing for professional misunderstandings and which allows for perceived inequities of the system to be brought into focus.

e) An ongoing data analysis related to potential over- or underutilization of the health care system, attesting to the performance of the system, and able to assure the various fiscal intermediaries that they are not paying out monies for services that have been deemed unnecessary.

To implement an effective review system, new legislation or radical change is not required. What is needed

is an agreement that one system be used. In terms of ease of implementation, the use of the current federal system would be easiest. Such adoption would provide for avoidance of conflict with federal regulations and has the additional advantage of containing a mechanism for addressing quality of care problems which is interactive with the various hospital quality assurance committees as well as to a statewide committee.

What is lacking is one agency with the willingness to provide leadership and personnel to act as the coordinating force in such an endeavor. Rightfully, this role should be filled by NJDOH. However, this agency has not provided much in the way of input and has been unable even to provide any changes in regulations despite some attempts to do so. The change in health commissioners may have contributed to this problem.

An alternative is to designate one or another of the state's utilization review organizations (UROs) as the coordinating force under NJDOH auspices for development of a meaningful review program and to support the need for change. In this fashion, the commissioner could review suggested changes and approve or disapprove the changes that did not seem workable.

The appeals mechanisms necessary already are in place but need clarification for nonfederal patients.

There is a considerable amount of peer review data available: UROs, NJDOH, and the fiscal intermediaries. However, no monies have ever been appropriated to provide analysis of this data, and no agency has bothered to correlate it.

Designation of a group or agency should occur to provide for ongoing statistical analysis by DRG, and perhaps by diagnosis within DRGs, of this data on a yearly basis. This data should be confidential. Finally, analyzed data should be reported back to NJDOH for publication as needed.

There should be an appropriation of monies for data analysis by UROs as well.

The appeals mechanisms necessary already are in place but need clarification for nonfederal patients. Again, the federal model might be useful.

There is a need for data to be gathered which firmly ties the review process to the payment of bills by fiscal intermediaries. Such data elements are secured easily, but penalties for not collecting them should be in place to ensure that this is done.

There also is a need for a change in attitude on the part of the entire health care industry towards the issue of measurement of quality of care. Unlike modern industrial operations, there are no clear value systems or technologies in place by which to judge quality of medical care. Rather, peer review efforts to direct attention to quality issues have been greeted with fear, trepidation, and outright denial.

What is needed is a recognition that problems do exist and will always exist, and that by studying these

problems, corrective solutions can be devised which will result in overall system improvement and better future care.

Additionally, such a program has the capacity to expand its services into other areas such as long-term care; and, it has the capacity to generate evaluations as to needs in particular facets of a developing, meaningful, accessible health care system.

CONCLUSION

Presently, meaningful peer review of patient care in New Jersey is at a crossroad. The potential for physician-directed effective peer review of all patients in this state does exist if the bureaucratic elements in the state and federal government desire its implementation.

The multiplicity of review programs, with their varying requirements and regulations, waste time and lack orientation to specific patients. A unified type of review program is desirable and achievable.

Each of these programs is underfunded. The Medicaid program is not funded, and the lack of funding has hampered seriously the orderly development of the peer review program in this state; it has forced partici-

pating organizations to compete for funds, impacting seriously on their capacities to work for necessary improvements in the assessment of the quality of care delivered to the patients treated in New Jersey.

Effective coordination would produce a reasonable review program. Its absence contributes materially to the present fragmentation and increasing chaos that is rapidly diminishing and eventually will do away with the peer review process in this state.

Finally, there is a need for the medical profession, as well as for the health care industry, to change its attitude toward measurements of the quality of care—to recognize that problems do exist, to realize problems will be found, and to know corrective solutions can be formulated.

REFERENCES

1. Public Law 92-603, Section 249F, 1972.
2. Legislative Act 78, Chapter 83, Section 11C (New Jersey) 1982.
3. *Medical Utilization Review, Volume 14 and 15*. New York, NY, McGraw-Hill Publishing, 1988.
4. Pilot Project on Ancillary Services Review, Passaic Valley PSRO—1980 (HCFA Special Projects Archives).
5. Sapolovsky HM: An evaluation of the New Jersey DRG hospital payment system. *NJ MED* 85:32-37, 1985.

**Trustees' Minutes; UMDNJ
Notes; Auxiliary Report;
Physicians Seeking Location
in New Jersey**

**Trustees' Minutes
December 18, 1988**

A regular meeting of the Board of Trustees was held on December 18, 1988, at the executive offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

NJ Commissioner of Health . . . Welcomed Molly Joel Coye, M.D., M.P.H., who noted: the Health Department is proceeding with AIDS legislation to provide immunity for physicians who warn partners of people who are HIV positive; her agreement to write articles for publication in *NEW JERSEY MEDICINE*; her willingness to answer questions concerning the hospital reimbursement reform; the Health Department's work to extend the Uncompensated Care Trust Fund; an agreement to call a meeting to achieve a more logical protocol for physicians in nursing homes when dealing with decisions to withdraw or withhold life-sustaining medical diagnosis or treatment of patients over 60 years of age; and the results

of the computerized severity of index project.

Report of the President . . . Noted that Dr. Formica stated the AMA was unified in its stance on the Resource-Based Relative Value Scale and her letter to the membership concerning PRO quality reviews.

Report of Executive Director . . .

(1) Membership . . . Noted membership total is consistent with reports from last year at this time.

(2) MSNJ Financial Statements . . . Reviewed and approved MSNJ financial statements for the period ending November 30, 1988.

(3) Medical Malpractice Surcharge . . . Noted that MSNJ is attempting to meet with the attorney general prior to the anticipated action of the insurance commissioner to urge against adoption of the surcharge rule.

(4) Medical Discipline and Licensing—S-2936 . . . Noted that the position of conditional approval was taken by the Council on Legislation, pending incorporation of suggested amendments.

(5) Litigation—MSNJ versus State Board of Physical Therapy . . . Agreed to send a letter of commendation to Steven I. Kern, Esq., who represented MSNJ in this successful case.

(6) Medicare Medically Unnecessary Determinations—AMA Response . . . Noted that physicians who have had adverse determinations to forward the information to the AMA general counsel or to MSNJ to be entered as testimony.

(7) State Board of Medical Examiners Action Against Anesthesiologist . . . Approved the Society's amicus entry into this case.

(8) Verification and Attestation Requirements Under Medicare . . . Noted that beginning January 1, 1989, physicians will be required to verify on each patient's chart that the patient was treated as ordered and that all services performed were medically necessary.

UMDNJ Report . . . Received a report from Stanley Bergen, Jr., M.D., highlighting: a federal contract awarded to UMDNJ to determine how pregnant women infected with the AIDS virus transmit the disease to their babies; the full seven-year accreditation for UMDNJ-Robert

Wood Johnson Medical School's teaching and patient care programs; implementation of the smoke-free environment for UMDNJ by March 20, 1989; the opening of the Comprehensive Epilepsy Center; and the reappointment of Dr. Bergen for another five-year term as president of UMDNJ.

NJ Hospital Association . . . Received a report by Louis Scibetta highlighting: the termination of the Medicare waiver; a lawsuit filed by NJHA against the Office of the Ombudsman for the Institutionalized Elderly opposing the admonitions they have issued to the administrators of psychiatric hospitals and nursing homes; the Association's neutral position on the medical malpractice surcharge proposal; HCFA's mortality and morbidity statistics showing four hospitals as being above the death rate level projected for New Jersey; and the appearance of NJHA before the Hospital Rate-Setting Commission to present its appeal for increased dollars for labor.

Ad Hoc Committee on Graduates of Non-U.S. Medical Schools . . . Approved the following three recommendations:

That the Medical Society of New Jersey take a position of support for a single common examination for medical licensure to be given to graduates of American and non-American medical schools.

That Stanley S. Bergen, Jr., M.D., president of UMDNJ, be requested to address the position and future of graduates of non-American medical schools in New Jersey; i.e. that they be permitted to compete for all types of residencies based on a common standard of evaluation.

That UMDNJ be encouraged to participate in a faculty exchange program with non-U.S. medical schools in New Jersey.

Postponed consideration of H.R. 3241 and H.R. 3273 pending receipt of analyses from the AMA.

Academy of Medicine of New Jersey . . . Noted that Drs. Ervin Moss and James Oleske will be the co-recipients of the Edward J. Ill Award.

AMA Interim Meeting . . .
(1) Resource-Based Relative Value Scale (RBRVS) . . . Noted that policy makes AMA support of that

study contingent on restudy of some specialties, expansion to others, and improvements in its measurement of practice and training costs and extrapolations to services that were not measured directly.

(2) Registered Care Technologists

... Noted that the AMA adopted the following amended resolution:

That the AMA continue to seek solutions to the problem of the shortage of bedside caregivers, in addition to the Registered Care Technologists Program.

That the AMA, recognizing the concerns of our partners in health care, the nursing profession, work together with the American Nurses' Association and other nursing organizations to address the nursing shortage, and to continue to seek innovative ways to alleviate the acute shortage of bedside care providers, and that the Board of Trustees report to the House of Delegates at the Annual Meeting in 1989.

(3) Antitrust Enforcement ...

Noted a major policy speech by Charles F. Rule, head of the Antitrust Division of the U.S. Justice Department, warning that felony criminal charges will be leveled against competing physicians if they fix fees, allocate patient territories, or boycott insurers.

(4) Retiring Members of the Del-

egation ... Commended retiring members Drs. Alessi and Krueger for their outstanding and dedicated service.

(5) Medically Unnecessary Statements ... Adopted the following policy:

That the AMA continue to call for the repeal of the medically unnecessary provisions of section 9332(c) of the Omnibus Budget Reconciliation Act of 1986; and

That until such time as repeal is achieved, the AMA urge the Health Care Financing Administration to require that there be stated on the medically unnecessary notices mailed by carriers (a) the basis for the denial; (b) the name, position, and title of the person to be contacted regarding questions about the review; and (c) the screening criteria or parameter used in denying payment for the service.

(6) Hospital Medical Staff Section

... Noted the following three resolutions from the New Jersey delegation were adopted in various forms: a) Proposed Joint Commission on Accreditation on Health-care Organizations—asked the AMA to urge members of JCAHO to oppose vigorously adoption of any changes in the *Accreditation Manual for Hospitals*; b) Hospital Health Care Delivery—asked the AMA to study means to increase the num-

bers of technologists in all hospital support areas for quality health care delivery; and c) Clear Communication of the Principle and Use of the Terms "Fee" Versus "Payment Schedule"—asked the AMA to fight for enactment of the principle that medical payment schedules be divorced from and independent of medical fees which are the sole prerogative of the individual practitioner and in the RBRVS report the term should be indemnity payment schedule.

MSNJ Auxiliary ... Noted new look of *The Shingle* and of the plans for the trip to Washington, D.C. on April 12-13, 1989.

Committee on Membership Services ... Adopted the following recommendation:

That the Society adopt the position that when the cause for the suspension or retirement of a member's license is verified as a physical or emotional illness, that member will be carried in the retired physician category and his or her eligibility for insurance coverage will continue through that Society's group plan.

Committee on Publication ... Approved the following:

That the Board of Trustees approve Trentypoint, Inc., and Hughes Printing Company as the production companies for *NEW JERSEY MEDICINE* for 1989 and 1990.

Committee on Long-Range Planning and Development ...

(1) County Society Forums ... Approved the following resolutions:

That the format for inviting the general membership of county societies to attend specific meetings of the Board be continued.

That county societies be asked to provide a list of the issues to be discussed and to supply relevant data to assist in the deliberation of the issues.

That county societies be encouraged to review issues at their monthly meeting, so that their membership is informed and prepared to address the topics when presented to the Board at the county society forum.

(2) Invitation to MSNJ Leadership To Attend County Society Meetings

... Approved the following recommendation:

That the county medical societies be

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Category: (Please check one)

☐ Member, MSNJ ☐ Subscriber, NJ Medicine

☐ Other _____

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____

asked to extend an invitation to officers of MSNJ, on a rotating basis, to meet with the leadership of the county at their monthly meetings for a discussion of issues, to be followed by an open meeting with the general membership of the county.

(3) Resources Available to County Medical Societies . . . Approved the following recommendation:

That, on a yearly basis, the presidents of county medical societies, medical specialty societies, and hospital medical staffs be notified directly of the people who are available through MSNJ to speak on issues.

Committee on Physicians' Health . . . Approved the following recommendation:

That the Board of Trustees approve the Protocol for Referrals from the State Board of Medical Examiners as program policy.

Also, voted to donate a gift of \$1,000 to the program to assist less fortunate physicians and their families during the holiday season.

Committee on Cancer Control . . . Approved as amended the following recommendation:

That the Medical Society of New Jersey urge the Department of Insurance to require insurance carriers to recognize the implantable infusion pump as being valid for reimbursement purposes when used for the intrathecal or epidural administration of medication for the treatment of intractable pain.

Task Force on the Shortage of Nurses and Technical Personnel . . .

(1) Work Environment . . . Approved the following two recommendations:

That New Jersey hospitals be requested to institute a mechanism to enhance professional relationships and patient care at their institutions.

That the Medical Society of New Jersey and the New Jersey Hospital Association cosponsor a symposium for the purpose of assisting hospitals in implementing this endeavor.

(2) Contributing Factors to the Nursing Shortage . . . Noted the factors which have impacted on the shortage include workload and need for support personnel; noted the consensus of the Task Force that a major reason for the present nursing

shortage is due to the environmental factors which place an unbearable workload on nurses.

Committee on Biomedical Ethics . . . Approved the following recommendations:

That correspondence be drafted by MSNJ legal counsel requesting a meeting with representatives of MSNJ, the Office of the Ombudsman, the Department of Health, the State Board of Medical Examiners, the Office of the Attorney General, and the Governor's Legal Counsel to review the ombudsman's letter to clarify the issue.

That a letter to administrators of New Jersey nursing homes be prepared by MSNJ legal counsel and Paul Armstrong, J.D., consultant to the Committee on Biomedical Ethics, advising nursing home administrators to continue with current practice and norms until such time as specific guidelines are established.

That the Do Not Resuscitate Guidelines, as established by MSNJ and the New Jersey Hospital Association, be approved and forwarded to New Jersey nursing homes, acute bed hospitals, the Department of Health, the State Board of Medical Examiners, the Governor's Commission on Biomedical Ethics, and other appropriate state agencies.

New Business . . .

(1) UMDNJ—Department of Family Medicine . . . Noted that a letter be sent to Dr. Bergen asking that a better liaison between UMDNJ and the New Jersey Academy of Family Medicine be encouraged.

UMDNJ Notes

Stanley S. Bergen, Jr., M.D. President

A \$13.8 million investigation of the increasing transmission of the AIDS virus among heterosexuals solely through sexual contact began at UMDNJ. The study, the largest of its kind, will track 1,000 heterosexual men and women over five years. It is funded by the National Institute of Allergy and Infectious Diseases (NIAID), part of the National Institutes of Health (NIH), and represents the largest single research award ever received by the university. It also is the second major AIDS research grant awarded to UMDNJ by NIAID.

The newest research comes at a time when New Jersey is recording twice as many heterosexual AIDS cases related to heterosexual activity

as are recorded nationally.

"The sexual transmission and progression of AIDS among heterosexuals is virtually unexplored territory," said Stanley H. Weiss, M.D., principal investigator of the study and one of the nation's leading AIDS researchers. "In effect, we will be helping to write the book on this subject. We hope our efforts will lead to ways to halt the transmission and progression of the disease."

The study—based in Newark at UMDNJ-New Jersey Medical School—will be conducted in Newark, Paterson, and Jersey City, cities identified as having comparatively high numbers of heterosexuals infected with human immunodeficiency virus (HIV), which causes AIDS.

The researchers will be seeking co-factors, or markers, that increase the risk of HIV infection. Examples of potential co-factors include sexually transmitted diseases or exposure to human retroviruses, a category of viruses that includes the AIDS virus.

"We need to construct a comprehensive profile of heterosexual AIDS so that we can recognize the condition as early as possible and formulate a viable battle plan," Dr. Weiss explained.

The investigation will harness the AIDS research and clinical experience of the university and four hospitals in the forefront of fighting the epidemic in northern New Jersey. They are UMDNJ-University Hospital and Saint Michael's Medical Center, both in Newark; St. Joseph's Hospital and Medical Center in Paterson, and Jersey City Medical Center. The New Jersey State Department of Health also is collaborating.

When it comes to identifying whether their child is gifted, mom and dad are right about two out of three times, says Dr. Michael Lewis, director of the Institute for the Study of Child Development at UMDNJ's Robert Wood Johnson Medical School in New Brunswick. Dr. Lewis's estimate is based on four years of work at his Gifted Child Clinic with more than 350 children, ages 18 months to five years. The Institute is one of the few places in the nation that evaluates very young children to determine if they are gifted.

Dr. Lewis maintains that there is

a strong relationship between a parent's belief about their child's giftedness and the actual abilities of the child.

"Parents correctly use a wide variety of behaviors to recognize that their child is gifted," the professor of pediatrics says. He said they cite such skills as creativity, imagination, abstract reasoning, and ability to memorize.

According to his studies, indicators of childhood giftedness include high levels of pretend play, a sense of humor, daydreaming, abstract reasoning, and the ability to categorize. He says that rote learning, such as counting to ten, is not an indicator.

One of the goals of the Institute is to develop a screening mechanism parents can use to determine if their children are gifted. All parents, says

Dr. Lewis, should be aware of their child's intelligence before he or she goes to school because without pre-school enrichment experiences, recognition and encouragement, a child may never develop to his full potential.

UMDNJ's Foundation recently celebrated the achievement of its \$27.5 million fundraising goal to benefit UMDNJ priority programs. Campaign chairman Edward L. Hennessy, Jr., chairman and chief executive officer of Allied-Signal Inc., commended donors for sharing in the public-private partnership that is "providing the margin of excellence necessary to build an outstanding academic health-sciences center in New Jersey."

Finally, as I'm sure most of you know, I was recently reappointed to another five-year term as UMDNJ's

president. I have been with this institution virtually since its inception, and I now feel as proud and energized regarding its future as I did then, back in 1971, when the university was just getting underway.

From the beginning, growth has been the UMDNJ byword; and grow it has—in leaps and bounds. That I can now lead UMDNJ into the next decade, and be a part of that continuing growth, is greatly gratifying. I look forward to working with all of you for the benefit of this great university.

Auxiliary Report

Marion Geib

In keeping with its 1988-1989 education theme, the Medical Society of New Jersey Auxiliary recently

1989 MSNJ Annual Meeting

The Board of Trustees of the Medical Society of New Jersey at its September 18, 1988, meeting, approved the Committee on Annual Meeting recommendation that the 1989 Annual Meeting be held at the Sheraton Meadowlands Hotel in East Rutherford, on Thursday, April 27, through Sunday, April 30, 1989.

The daily schedule follows:

Wednesday, April 26, 1989

3:30 P.M. Board of Trustees' Meeting

Thursday, April 27, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

10:00 A.M. House of Delegates

11:00 A.M. Exhibits Open

1:00 P.M. Program—Topic of Major Interest to Physicians

3:30 P.M. Reference Committee Meetings

Friday, April 28, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

8:30 A.M. Exhibits Open

9:00 A.M. House of Delegates (Election)

12:00 NOON Golden Merit Award Ceremony and Reception

2:30 P.M. Reference Committee Meetings

5:00 P.M. JEMPAC Political Forum

Friday, April 28, 1989

5:45 P.M. JEMPAC Wine and Cheese Reception

6:30 P.M. Middlesex County Medical Society Reception

Saturday, April 29, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

8:30 A.M. Exhibits Open

9:00 A.M. House of Delegates

1:30 P.M. House of Delegates

2:00 P.M. Exhibits Close

6:00 P.M. Inaugural Reception and Dinner

Sunday, April 30, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

8:30 A.M. General Session—Topic of Major Interest to Physicians

1:00 P.M. Board of Trustees' Meeting

The daily schedule for Thursday, April 27 has been revised. Changes include the scheduling of the House of Delegates opening session at 10:00 A.M. on Thursday, April 27, 1989, and an educational program from 1:00 P.M. to 3:00 P.M., that same day.

The topics for the education programs scheduled for 1:00 P.M., Thursday, April 27, and 8:30 A.M., Sunday, April 30 will be announced at a later date.

The Inaugural Reception and Dinner-Dance honoring President-Elect Paul J. Hirsch, M.D., will be held on Saturday, April 29, 1989.

sponsored an "Adolescent Health Symposium" at MSNJ headquarters. The full morning session, attended by New Jersey teachers, principals, counselors, and nurses, was designed to inform educators about the unique problems, pressures, and challenges faced by today's teenagers and to present available measures or interventions to appropriately meet the needs of adolescents. The topics covered at the symposium included suicide, drug abuse, runaways, and psychiatric facilities—each addressed by an expert in the field.

Many interesting points were discussed. According to family counselor and auxiliary member, Rosemarie Scolaro-Moser, Ph.D., 5,000 persons under the age of 19 commit suicide each year, and 50,000 attempt suicide. Suicide now is the third leading cause of teen deaths—a 300 percent increase since 1950. Furthermore, many of these victims are intoxicated with drugs or alcohol when the suicide occurs.

Ed Reading, M. Div., liaison representative to the New Jersey Schools on Drug Education, pointed out that the state of New Jersey formally has recognized the existence of a drug problem in its schools by mandating, effective immediately, each school to maintain a full-time, state-certified substance awareness coordinator. Among other qualifications, the coordinator must have training in child and adolescent development, coordination and delivery of intervention and referral services within the school setting, evaluation and counseling for drug and alcohol problems affecting students and families, and a 6- to 12-month residency-internship training program. This mandate is significant in that it marks a dramatic change and a new direction in the overall approach taken in schools in dealing with alcohol and drug abuse.

Lawrence T. DeMilio, M.D., director adolescent services, Carrier Foundation, discussed the topic, "Adolescent Admission to a Psychiatric Facility." Dr. DeMilio elaborated on the features of a psychiatric facility for adolescents and the spectrum of services it can provide. He noted that one tool of service is hospitalization. A hospital's artificial setting is a powerful maneuver because it has a con-

trolled environment where an adolescent, removed from all external static (family, neighbors, previous dangers, and reinforcers), can be observed round-the-clock in an undistorted and objective manner. Hospitals also can provide a multi-approach—including peer role groups, therapy units, and intervention techniques.

Finally, Judy Donohoe from Anchor House in Trenton, spoke on teen runaways. She claimed there are one million runaways a year, including throwaways or homeless children; many are trying to escape abuse or family problems. Runaways use drugs and are sexually active. Prostitution is common and AIDS is a growing problem. Anchor House is open 24 hours a day to provide food, shelter, clothing, counseling, and medical services. Recognizing, however, that neither Anchor House nor any other facility or service can solve adolescent problems alone, the Auxiliary has launched programs in counties throughout the state. By informing teens and the public about drug abuse, suicide, runaways, and AIDS, and by offering help and support to those in need, the Auxiliary hopes to make a positive difference in the quality of life of our greatest national resource—our children.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Robert C. Mayer, M.D., 32 Pebble Beach Cir., Glendale Heights, IL 60139. Ross University 1985. Board eligible. Group or partnership. Available.

FAMILY PRACTICE—Eileen Hill, M.D., 155 Briarwood Rd., Mt. Laurel, NJ 08054. Pennsylvania 1980. Board certified. Part time. Available March 1989.

GASTROENTEROLOGY—Curtis Freeland, D.O., 25601 Briar Dr., Oak Park, MI 48237. Des Moines College of Osteopathic Medicine and Surgery 1981. Board eligible. Group or partnership. Available July 1989.

Robert I. Leventhal, M.D., 1000 J Scaife Hall Division of Gastro-

enterology, University of Pittsburgh, Pittsburgh, PA 15217. St. Georges (Grenada) 1984. Board eligible. Consultative, group, partnership, solo. Available July 1989.

HEMATOLOGY—Vijaykumar Gandhi, M.D., 12126 Chapin Apts., SUNY, Stony Brook, NY 11794. Baroda (India) 1981. Board eligible. Board certified (IM). Group partnership, solo. Available.

INTERNAL MEDICINE—Ezra Bendit, M.D., 22 Mt. Rascal Rd., Hackettstown, NJ. UMDNJ 1984. Board certified. Group or partnership. Available.

Michael T. Burgio, M.D., 54 Jefferson Ave., Pompton Lakes, NJ 07442. St. George's 1985. Board eligible. Group or partnership. Available July 1989.

Bhuvana Chinnappan, M.D., 139 Wm. Feather Dr., Voorhees, NJ 08043. Board eligible. Group, partnership, solo. Available.

Rekha B. Daftary, M.D., 5 Willow Dr., Chester, NJ 07930. Kasturba (India) 1980. Board eligible. Partnership or group. Available.

Leon G. DeMasi, M.D., 24 Whitechapel Dr., Mt. Laurel, NJ 08054. Temple 1979. Board eligible. Solo. Available 1989.

Chris William Fellin, M.D., 135 Man-ning Terrace Apts., Danville, PA 17821. Hahnemann 1986. Board eligible. Partnership or group. Available July 1989.

Albert S. Ford, M.D., 4 Linden Lane, Scotch Plains, NJ 07076. Meharry (India) 1982. Board eligible. Solo. Available.

Eric B. Hatton, M.D., 800 Rosewood Dr., Clovis, NM 88101. Boston 1982. Board eligible. Group. Available July 1989.

Lalitha B. Iyer, M.D., 35 Winthrop Rd., Edison, NJ 08817. Madras (India) 1980. Board eligible. Group, partnership, emergency room. Available.

Donald Mitran, M.D., 129 Broadway, Apt. C., Huntington Station, NY 11746. Columbia 1989. Board eligible. Group or partnership. Available July 1989.

OPHTHALMOLOGY—William Brian Neusidl, M.D., 200 Riverfront Pk., Apt. 13C, Detroit, MI 48226. Temple 1984. Board eligible. Available July 1989.

ORTHOPEDICS—Joseph M. Grant, M.D., Naval Hospital, Box 8, FPO, San Francisco, CA. UMDNJ 1980. Board eligible. Group or partnership. Available July 1989.

PEDIATRICS—Leena D. Parikh, M.D., 1290 Twin Streams Dr., Warminster, PA 18974. B.J. Medical (India) 1972. Board eligible. Group, partnership, solo. Available.

RADIOLOGY—Robert W. Cifers, M.D., 6913 Bonnie Ridge Dr., Apt. T1, Baltimore, MD 21209. Ohio State 1983. Board eligible. Also, nuclear medicine. Group, partnership, solo. Available May 1989.

WHOM TO CALL AT MSNJ HEADQUARTERS

Executive Director: Vincent A. Maressa

Address changes	Joyce Guest	Long-Range Planning	
Advertising (in NEW JERSEY		Committee	Vincent A. Maressa
MEDICINE)	Joseph Cookson	Loss Prevention, Risk	
AIDS Task Force	A. Ronald Rouse	Management	A. Ronald Rouse
AMA Delegation	Diana C. Gore	Maternal and Newborn Record	
Annual Meeting	Eileen Pfeiffer	Books	Joyce Guest
Auxiliary, MSNJ	Margaret Fransckiewich	Medical Assistants	Joseph C. Lucci
Biomedical Ethics	June O'Hare	Medical Education	Martin E. Johnson
Blue Cross/Blue Shield	Joseph C. Lucci	Medical Services	Joseph C. Lucci
Board of Trustees	Diana C. Gore	Medical Student Loan	
CME	Marge Bolling	Fund	Patricia Drakeford
Council and Committee		Medicare/Medicaid	Joseph C. Lucci
Appointments	Diana C. Gore	Membership Benefits	Joseph C. Lucci
Credentials	Mary Hamer	<i>Membership Directory</i>	Joyce Guest
Delegates, MSNJ	Eileen M. Pfeiffer	Membership Records	Mary Hamer
DRG	Vincent A. Maressa	Mental Health	Joseph C. Lucci
Dues Payments: MSNJ and		NEW JERSEY MEDICINE .	Geraldine Hutner
AMA	Mary Hamer	Nominating Committee	Diana C. Gore
Eye Health Screening		Officers of MSNJ	Diana C. Gore
Program	Patricia Hackett	PRO	Vincent A. Maressa
Executive Committee	Diana C. Gore	Professional Liability	
Financial Operations	Arthur White	Insurance	A. Ronald Rouse
HMOs/IPAs/PPOs	Joseph C. Lucci	Public Health	Joseph C. Lucci
Hospital Medical Staff		Public Relations	Martin E. Johnson
Relations	Diana C. Gore	Resident Association	A. Ronald Rouse
House of Delegates	Diana C. Gore	Resolutions for Annual	
Impaired Physicians		Meeting	Diana C. Gore
Program	David I. Canavan, M.D.	Senior Citizen Projects	A. Ronald Rouse
	Linda A. Pleva	Special Projects	A. Ronald Rouse
JEMPAC	June O'Hare	Specialty Societies	Patricia Hackett
Judicial Council	June O'Hare	Student Association	A. Ronald Rouse
Legal Services Plan	Joseph C. Lucci	Subscriptions	Robin L. Kennett
Legal Questions	Vincent A. Maressa	Third-Party Payor	
Legislation	June O'Hare	Complaints	Joseph C. Lucci
Liaison Representatives to Other		Widows and Orphans Program .	Joyce Guest
Organizations	Diana C. Gore	Women Membership	Martin E. Johnson
		Young Physicians	A. Ronald Rouse

MSNJ-609-896-1766

CME CALENDAR

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization (indicated in italics) for further information.

ANESTHESIOLOGY

March

- 11 30th Annual Postgraduate**
- 12 Seminar**
The Hyatt, Cherry Hill
(*NJ State Society of Anesthesiologists*)

April

- 5 Neuroanesthesia**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*AMNJ*)

CARDIOLOGY

March

- 15 Post-Infarction**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(*Christ Hospital*)

April

- 12 Percutaneous Transluminal Coronary Angioplasty**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*AMNJ*)

DERMATOLOGY

March

- 1 Overview for the Primary Care Physician on Dermatology**
7-9 P.M.—The Villa Mattar, Allamuchy
(*Hackettstown Community Hospital*)
- 14 Dermatological Society of New Jersey**
7-10 P.M.—Sehering-Plough Corporation, Kenilworth
(*Dermatological Society of New Jersey*)

- 14 Dermatological Conferences**
6-9 P.M.—Rutgers Community Health Center, 57 U.S. Highway 1 South, New Brunswick
(*UMDNJ*)

April

- 11 Dermatological Society of New Jersey**
7-10 P.M.—Sehering-Plough Corporation, Kenilworth
(*Dermatological Society of New Jersey*)
- 12 Dermatological Conferences**
6-9 P.M.—Rutgers Community Health Center, 57 U.S. Highway 1 South, New Brunswick
(*UMDNJ*)

INFECTIOUS DISEASES

March

- 1 Counseling, Testing, and**
- 15 Management for HIV Infection**
9-10 A.M.—Warren Hospital, Warren
(*AMNJ*)
- 7 Clinical Management of HIV Infection**
11-12 noon—St. Francis Hospital, Jersey City
(*AMNJ*)
- 10 Counseling and Testing for HIV Infection**
10:45-11:45 A.M.—Greystone Park Psychiatric Hospital, Greystone Park
(*AMNJ and NJSDOH*)
- 15 AIDS—Medical Malpractice, Criminal Law, and Tort Issues**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*AMNJ*)

April

- 10 Counseling and Testing for HIV Infection**
7:30-8:30 A.M.—Newcomb Medical Center, Vineland
(*AMNJ and NJSDOH*)
- 28 Counseling and Testing for HIV Infection**
7:30-8:30 A.M.—Atlantic City Medical Center, Atlantic City
(*AMNJ*)

MEDICINE

March

- 1 Proper Use of Antibiotics**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic
(*AMNJ*)
- 1 Arthritis**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(*AMNJ*)
- 3 Pulmonary Function Testing**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(*Bridgeton Hospital*)
- 8 Winter Dinner Meeting**
6:30-9:30 P.M.—Hilton at Short Hills
(*NJ Gastroenterological Society*)
- 9-37th Annual Meeting**
- 12 Bally's Park Place Casino Hotel, Atlantic City**
(*NJ Academy of Family Physicians*)

- 10 Sleep Disorders**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(*Bridgeton Hospital*)
- 10 Laser Treatment for Gastrointestinal Bleeding**
1-2 P.M.—Woodbine Developmental Center, Woodbine
(*AMNJ*)
- 10 1989 Cranio-Facial Pain Conference**
All-day—Tropworld Casino and Entertainment Resort, Atlantic City
(*Cranio-Facial Pain Center, Philadelphia*)
- 14 Urinary Incontinence in the Elderly**
10-11 A.M.—Green Brook Regional Center, Green Brook
(*AMNJ*)
- 16 Proper Use of Endoscopy**
1:30-2:30 P.M.—Vineland Developmental Center, Vineland
(*AMNJ*)
- 16 Physical Assessment of the Severely Disabled**
10-11 A.M.—Woodbridge Developmental Center, Woodbridge
(*AMNJ*)
- 17 Pseudomembraneous Colitis**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(*Bridgeton Hospital*)
- 23 Visiting Professor Program**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(*Saint Barnabas Medical Center*)
- 24 Management of Abdominal Emergencies**
7:30-8:30 A.M.—Atlantic City Medical Center, Atlantic City
(*AMNJ*)
- 31 Indications for Color Doppler Studies**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(*Bridgeton Hospital*)
- 31 Colitis**
9-10 A.M.—St. Francis Medical Center, Trenton
(*AMNJ*)

April

- 5 Otto Brandman, M.D., Award Ceremony**
6-10 P.M.—The Hyatt Regency, New Brunswick
(*American Diabetes Association*)
- 5 Malpractice**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(*AMNJ*)
- 12 Nonoperative Management of Chronic Back Pain**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(*AMNJ*)
- 19 Child Abuse**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(*AMNJ*)
- 19 The Primary Physician and Saving Diabetic Legs**
12 noon-1 P.M.—Welkind Rehabilitation Hospital, Chester
(*AMNJ*)



Hahnemann University

**DEPARTMENT OF MEDICINE
MEDICAL SEMINAR SERIES**

MARCH 1989

MARCH 15, 1989

Diagnosis of Heart Disease with Imaging

Course Co-Directors:

Marvin E. Haskins, M.D.
Professor and Chairman
Department of Diagnostic Radiology

Robert M. MacMillan, M.D.
Associate Professor of Medicine and Radiology
Department of Medicine
Likoff Cardiovascular Institute

MARCH 29, 1989

**Edema and Related Acid Base and
Electrolyte Disorders**

Course Director:

Allan B. Schwartz, M.D.
Professor of Medicine and
Director, Graduate Medical Education
Department of Medicine

Guest Faculty:

Neil A. Kurtzman, M.D.
Arnett Professor of Medicine
Professor of Physiology
Chairman, Department of Internal Medicine
Texas Tech University Health Sciences Center,
Lubbock, Texas

SEMINAR DIRECTORS

William S. Frankl, MD
Chairman, Dept. of Medicine
Director, Likoff Cardiovascular Institute

Allan B. Schwartz, MD
Professor of Medicine
Deputy Chairman, Graduate Medical Education

Classroom C (Alumni Hall),
College Building, 15th & Vine Streets
Hahnemann University, Philadelphia, Pennsylvania
For further information, please phone
(215) 448-8263



**MEDICAL ACUPUNCTURE 1989:
HISTORICAL AND SCIENTIFIC PERSPECTIVES,
MODERN CLINICAL APPLICATIONS**

7-8-9 April 1989

**Jefferson Medical College
Philadelphia, Pennsylvania**

AAMA and Jefferson Medical College are pleased to present an international symposium designed to be of value to all physicians interested in acupuncture, whether just getting oriented or already having a decade of experience. We have invited a small group of world-class lecturers, and have scheduled enough time for them to develop their topics and to respond to questions.

THE LECTURERS ... THE PROGRAM

PROF. PAUL UNSCHULD: Historical Background and Cultural Basis of Traditional Chinese Medical Thought

PROF. BRUCE POMERANZ: The Neurophysiology of Acupuncture

DR. DANIEL BENSKY: Integrating Acupuncture into a Modern Medical Practice, a Clinical Workshop

DR. CLAUDE ROUSTAN: Classical Acupuncture Techniques for Pain Management and General Medical Problems, a Clinical Workshop

DR. MICHAEL SMITH: Acupuncture, Addiction, and AIDS

*For further information contact:
The Office of Continuing Medical Education
1025 Walnut Street, Room G3
Philadelphia, PA 19107
(215) 928-6992*

PLEASE MARK YOUR CALENDARS NOW!

- 20 Humanism in the Practice of Medicine**
12 noon-1:30 P.M.—Somerset Medical Center, Somerville
(*Somerset Medical Center*)
- 21 Clinicopathological Case Presentation**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(*Bridgeton Hospital*)
- 27 Visiting Professor Program**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(*Saint Barnabas Medical Center*)

NEPHROLOGY

March

- 21 Drug Pharmacokinetics in Renal Failure**
6:30-9 P.M.—Overlook Hospital, Summit
(*Nephrology Society of New Jersey*)

April

- 18 Pathophysiology of Metabolic Alkalosis**
6:30-9:30 P.M.—Overlook Hospital, Summit
(*Nephrology Society of New Jersey*)
- 18 Chronic Renal Failure**
10:30-11:30 P.M.—St. Mary's Hospital, Passaic
(*AMNJ*)

ONCOLOGY

March

- 2 Cancer Research Colloquium**
9 3-4 P.M.—New Jersey Medical School, G-506B, Newark
16 (UMDNJ)
23
30
- 8 Tenth Annual Tumor Board Conference**
6-9 P.M.—MSNJ Headquarters, Lawrenceville
(*Oncology Society of New Jersey*)
- 29 Dinner Meeting**
6:30-9:20 P.M.—The Manor, West Orange
(*AMNJ-Radiation Oncology Section*)

April

- 6 Cancer Research Colloquium**
13 3-4 P.M.—New Jersey Medical School, G-506B, Newark
20 (UMDNJ)
27

ORTHOPEDICS

March

- 21 Nonoperative Management of Chronic Back Pain**
2-3 P.M.—Hunterdon Developmental Center, Clinton
(*AMNJ*)
- 28 Annual Spring Meeting**
Registry Hotel, Scottsdale, Arizona
(*New Jersey Orthopaedic Society*)

April

- 12 Nonoperative Management of Chronic Back Pain**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(*AMNJ*)

PATHOLOGY

March

- 16 How Can the Clinical Microbiologist Influence the Proper Use of Antimicrobial Agents?**
6:30 P.M.—Cook College, New Brunswick
(*American Society for Microbiologists*)

PEDIATRICS

April

- 19 Child Abuse**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(*AMNJ*)
- 28 New Issues in Pediatrics**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(*Bridgeton Hospital*)

PSYCHIATRY

March

- 1 Case Seminars To Improve Psychotherapeutic Technique**
8-10 P.M.—2 West Northfield Road, Livingston
(*Advanced Psychiatric Study Group*)
- 2 Generic Medications: Pros and Cons**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 9 Over the Counter Medications**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 16 Substance Abuse and Addiction**

12 noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

- 17 Systemic Lupus Erythematosus**
12 noon-1 P.M.—Trenton Psychiatric Hospital, West Trenton
(*Trenton Psychiatric Hospital*)
- 22 Elusive Satisfaction: Craving and Addiction**
All day—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 30 Psychopharmacology of Children**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

April

- 5 Case Seminars To Improve Psychotherapeutic Technique**
8-10 P.M.—2 West Northfield Road, Livingston
(*Advanced Psychiatric Study Group*)
- 5 Anxiety Disorders**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(*AMNJ*)
- 6 Biology of Personality**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 12 Terrorism—Natural Disaster—Abuse—War: The Activation of Post-Traumatic Stress Disorders**
All day—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 13 Brain Function in Schizophrenia**
12 noon-1 P.M.—Carrier

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Category: (Please check one)

☐ Member, MSNJ ☐ Subscriber, NJ Medicine

☐ Other _____

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____

"We take the worry out of computerizing"

- SM*RT PRACTICE Medical System by Wismer*Martin
- Unique "Instant" Conversion
- Personalized training and support

Your New Jersey Systems Consultant:

James P. Mathews III

(800) 528-7300

200 Gibraltar Road, Horsham, PA 19044 (215) 443-7910

INTERNATIONAL CONFERENCES™

1989 CME CRUISE/CONFERENCES ON MEDICO-LEGAL ISSUES & RISK MANAGEMENT—Caribbean, Mexico, Alaska/Canada, China/Orient, Scandinavia/Russia, Mediterranean, Black Sea, Trans Panama Canal. Approved for 24-28 CME Category 1 Credits (AMA/PRA) and AAFP prescribed credits. Excellent group rates on finest ships. Pre-scheduled in compliance with IRS requirements.

Information: **International Conferences**, 189 Lodge Ave., Huntington Station, NY 11746. (800) 521-0076 or (516) 549-0869.

Mini-Residency In Proctology and Diseases of the Colon

A course of instruction for the primary care physician interested in gaining competence in diagnosis and office procedures, including flexible sigmoidoscopy and colonoscopy.

Praeceptor: *Thomas Logio, M.D., F.A.C.S.*
Diplomate of the American Board of Surgery and the American Board of Colon and Rectal Surgery.

Locale: 151 Summit Ave., Summit
Time Commitment: One student, one week (Mo. and Thu.) Total = 20 hrs.
Sponsorship: Overlook Hospital, Summit, N.J.
Accreditation: Approved for 20 hrs. CME Category I credit.
Tuition: \$500
First vacancies: February 1989

FOR FURTHER INFORMATION AND REGISTRATION
CALL CORDIS GRIFFITH,
(201) 522-2852

TENTH ANNUAL

COMPREHENSIVE COURSE IN OCCUPATIONAL MEDICINE

UNIVERSITY OF MEDICINE AND
DENTISTRY OF NEW JERSEY

DEPT. OF ENVIRONMENTAL AND COMMUNITY MEDICINE
ROBERT WOOD JOHNSON MEDICAL SCHOOL
PISCATAWAY, NEW JERSEY

DATE:

May 8-25, 1989/15 weekdays/8:30 a.m.-4:30 p.m.,
6 evening classes/6:30-8:30 p.m.

PURPOSE:

To provide a comprehensive review of key issues and concepts in Occupational Medicine given by eminent specialists from university, government and industry. To aid in obtaining board eligibility and certification.

ACCREDITATION:

The University of Medicine and Dentistry of New Jersey-Office of Continuing Education certifies that this continuing medical education activity meets the criteria for 90 hours of credit in Category 1 for the Physician's Recognition Award of the American Medical Association, provided the program is completed as designed.

SUBJECTS:

Industrial Hygiene, Occupational Disease, Toxicology, Practice of Occupational Medicine, Epidemiology and Biostatistics, Ergonomics, Public Health Administration.

INQUIRIES:

Linda Adamec (201) 463-4707
UMDNJ-Office of Continuing Education
675 Hoes Lane, Piscataway, NJ 08854-5635

GARLIC, ASPIRIN AND A GLASS OF WINE

MEETING THE PUBLIC'S CHALLENGE: PREVENTIVE MEDICINE FOR THE 90's

APRIL 7 & 8, 1989

CLARIDGE CASINO HOTEL

Atlantic City, New Jersey

Keynote Speaker: Benjamin Spock, M.D.

PRACTICAL INSIGHTS ABOUT:

- ★ Cardiovascular Disease
- ★ Psychiatric Issues
- ★ Impact of the Environment
- ★ Communicable Disease

20 CATEGORY I A.M.A. CREDITS

SPONSORED BY:

Cooper Hospital/University Medical Center
The Clinical Campus for the University of Medicine and Dentistry of New Jersey/
Robert Wood Johnson Medical School at Camden

FOR FURTHER INFORMATION:

Ryna Alexander, Office of Continuing Medical Education
Cooper Hospital/University Medical Center
One Cooper Plaza, Camden, New Jersey 08103
(609) 342-3074

Foundation, Belle Mead
(Carrier Foundation)

20 Rape and Incest

12 noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)

PULMONARY

March

7 Pulmonary Conferences

14 8-9 A.M.—New Jersey Medical

21 School, H-349, Newark

28 (UMDNJ)

7 Pulmonary Case Conferences

14 8-9 A.M.—University Hospital,

21 New Brunswick

28 (UMDNJ)

April

4 Pulmonary Conferences

11 8-9 A.M.—New Jersey Medical

18 School, H-349, Newark

25 (UMDNJ)

4 Pulmonary Case Conferences

11 8-9 A.M.—University Hospital,

18 New Brunswick

25 (UMDNJ)

RADIOLOGY

March

**16 Radiological Society of
New Jersey Meeting**

7:30-9:30 P.M.—Saint Barnabas

Medical Center, Livingston
(Radiological Society of
New Jersey and AMNJ)

April

**13 Radiological Society of
New Jersey Meeting**

7:30-9:30 P.M.—Saint Barnabas

Medical Center, Livingston

(Radiological Society of

New Jersey and AMNJ)

14 Update in Diagnostic Radiology

12 noon-1 P.M.—Bridgeton Hospital,

Bridgeton

(Bridgeton Hospital)

**SURGERY AND SURGICAL
SPECIALTIES**

March

7 Surgical Grand Rounds

14 7-9 A.M.—Hackensack Medical

21 Center, Hackensack

28 (Hackensack Medical Center)

15 Eleventh Annual Meeting

Community Memorial Hospital,

Toms River

(Vascular Society of New Jersey)

**28 Medical Conditions Immediately
Following Atomic Bombing in
Nagasaki**

8-10 P.M.—Englewood Club,

Englewood

(Englewood Surgical Society)

April

4 Surgical Grand Rounds

11 7-9 A.M.—Hackensack Medical

18 Center, Hackensack

25 (Hackensack Medical Center)

7 Update on Laser Surgery

12 noon-1 P.M.—Bridgeton Hospital,

Bridgeton

(Bridgeton Hospital)

**25 Surgical Intra-abdominal
Infections**

8-10 P.M.—Englewood Club,

Englewood

(Englewood Surgical Society)

UROLOGY

March

8 Urology Rounds

6:20-8:30 P.M.—Robert Wood

Johnson Medical School, 108B,

New Brunswick

(UMDNJ)

16 Drug-Induced Renal Failure

12 noon-1:30 P.M.—Somerset

Medical Center, Somerville

(Somerset Medical Center)

April

12 Urology Rounds

6:20-8:30 P.M.—Robert Wood

Johnson Medical School, 108B,

New Brunswick

(UMDNJ)

1989 MSNJ Annual Meeting

The Board of Trustees of the Medical Society of New Jersey at its September 18, 1988, meeting, approved the Committee on Annual Meeting recommendation that the 1989 Annual Meeting be held at the Sheraton Meadowlands Hotel in East Rutherford, on Thursday, April 27, through Sunday, April 30, 1989.

The daily schedule follows:

Wednesday, April 26, 1989

3:30 P.M. Board of Trustees' Meeting

Thursday, April 27, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

10:00 A.M. House of Delegates

11:00 A.M. Exhibits Open

1:00 P.M. Program—Topic of Major Interest to
Physicians

3:30 P.M. Reference Committee Meetings

Friday, April 28, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

8:30 A.M. Exhibits Open

9:00 A.M. House of Delegates (Election)

12:00 NOON Golden Merit Award Ceremony and
Reception

2:30 P.M. Reference Committee Meetings

5:00 P.M. JEMPAC Political Forum

Friday, April 28, 1989

5:45 P.M. JEMPAC Wine and Cheese Reception

6:30 P.M. Middlesex County Medical Society
Reception

Saturday, April 29, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

8:30 A.M. Exhibits Open

9:00 A.M. House of Delegates

1:30 P.M. House of Delegates

2:00 P.M. Exhibits Close

6:00 P.M. Inaugural Reception and Dinner

Sunday, April 30, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

8:30 A.M. General Session—Topic of Major
Interest to Physicians

1:00 P.M. Board of Trustees' Meeting

Laboratory Investigations of Immunological Disorders; 1988 Year Book of Emergency Medicine; 1988 Year Book of Obstetrics and Gynecology

Laboratory Investigations of Immunological Disorders

Philadelphia, PA, W.B. Saunders, 1985.

Immunology is one of the most rapidly expanding fields of medicine that is "systemic" in nature, crossing the boundaries of organ-based clinical medical specialties. With the influx of information and subsequent technological advances, there has been an expanding use for immunological investigations. This volume looks at the predominant procedures, providing clear indications as to their significance and clinical value.

The text, although published in October 1985, is an extremely useful source of clinical information needed by many practicing physicians to interpret and utilize the ever-expanding immunological assays. The text covers immunoglobulin and complement abnormalities, primary and secondary immunodeficiencies, and neutrophil function, and then continues to focus on vari-

ous organ system-based disorders such as asthma, rhinitis, rheumatic disorders, immuno-neurology, malignancies, immunohematology, and autoimmune endocrinopathies. The clinical approaches to the evaluation of these disorders are given in practical algorithms, providing the information suitable for a physician to make logical "bedside" decisions. One obvious problem is the explosion of the immunological information regarding the acquired immunodeficiency syndrome (AIDS) since the publication of this text. A separate chapter is dedicated to the appropriate assessment of immune complexes with clear explanations of the various methods and their clinical application in renal, rheumatological, infectious, dermatological, and vasculitic disorders.

The present expansion of immunology requires all practicing physicians to understand more of the assays utilized to diagnose these once "uncommon" but now common disorders; a physician easily can do so with a review of this small text.

Leonard Bielory, M.D.

1988 Year Book of Emergency Medicine

David K. Wagner, M.D. Chicago, IL, Year Book Medical Publishers, 1988. Pp. 379. (\$44.95)

The same format is used in preparation of the *1988 Year Book of Emergency Medicine* as used in previous editions. However, in this issue, instead of limiting the material from one university medical center, material has been received from 14 medical centers and 18 contributing writers in the United States. There are 379 pages of abstracts taken from 700 U.S. and foreign medical and allied health journals.

The categories covered in this book are: acute systems pathophysiology, trauma emergencies, organ system emergencies, special emergencies, emergency procedure techniques and instrumentation, and emergency medical service systems. After each abstract there is an interpretive analysis of the particular ab-

stract. As in previous issues, the material is the result of research work. In view of the limited material on emergency medicine, in contrast with various texts on emergency medicine that have 800 to 1,000 pages of detailed emergency medical and diagrammatic material that can be used in the management and treatment of an emergency medical patient of all ages, this year book is not recommended for the emergency physician or hospital emergency department.

In addition, the price of the year book is within the range of the larger texts on emergency medicine. One important item missing in this book is state and federal regulations as they concern chemical industries and the "right to know" by employees of those industries.

Jack R. Karel, M.D.

1988 Year Book of Obstetrics and Gynecology

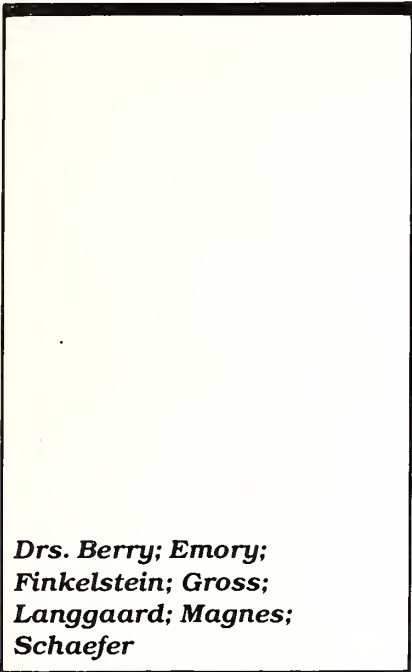
Daniel R. Mishell, Jr., M.D., Thomas H. Kirschbaum, M.D., C. Paul Morrow, M.D. Chicago, IL, Year Book Publishers, 1988. Pp. 523. (\$42.95)

The *Year Book* is an annual publication of reviews and digests of hundreds of articles of interest from nearly 90 national and international journals for obstetrician-gynecologists. Practically every article or group of articles is followed by a comment or critique from the three distinguished academicians serving as editors. Occasionally, there are references to articles and/or comments from previous editions of the *Year Book*. The publishers and their editors perform an enormously valuable service to the medical professional by providing, in a clear and concise manner, information that individual physicians would be unable to gather readily with the usual limitations of time and of resources.

The *Year Book* is particularly recommended for those in academia, those preparing for certification examinations, and/or anyone contemplating research into practically any and every topic in obstetrics and gynecology.

Jerome Abrams, M.D., M.P.H.

OBITUARIES



*Drs. Berry; Emory;
Finkelstein; Gross;
Langgaard; Magnes;
Schaefer*

Dr. C. Hartley Berry

Retired in Lake Wales, Florida, surgeon Clarence Hartley Berry, M.D., died on September 28, 1988. Born in Brantford, Canada, in 1906, Dr. Berry earned his medical degree at Queen's University Faculty of Medicine, Ontario, in 1930, and was licensed to practice in New Jersey in 1935. He was affiliated with the Summit Medical Group from 1935 to 1975, serving as chief surgeon for 12 years. Dr. Berry was chief of staff at Overlook Hospital, Summit, for 8 years. A resident of Lake Wales, Florida, for 14 years after his retirement, Dr. Berry served on the board of the Lake Wales Hospital. For 50 years of service, Dr. Berry received the Medical Society of New Jersey's Golden Merit Award in 1980. A fellow of the American College of Surgeons, Dr. Berry was a member of our Union County component and of the AMA.

Dr. George B. Emory, Jr.

Retired internal medicine specialist George Bache Emory, Jr., M.D., died on October 11, 1988. Born in 1913 in Newark, Dr. Emory earned his medical degree at Columbia University College of Physicians and Surgeons, New York, in 1938. He maintained a practice in Morristown, and was affiliated with Morristown Memorial Hospital, after receiving his New Jersey license to practice in 1940. Dr. Emory was a retired member of our Morris County component and of the American Medical Association. During the second World War, he served active duty with the U.S. Army, attaining the rank of captain.

Dr. Max Finkelstein

Max Finkelstein, M.D., a retired member of our Hudson County component, died on August 10, 1988. Born in Russia in 1905, Dr. Finkelstein earned his medical degree at Columbia University College of Physicians and Surgeons, New York, in 1931; he received his license to practice in New Jersey in 1946. During his lengthy career, Dr. Finkelstein was affiliated with Jersey City Medical Center, Fairmount Hospital, and Pollak Hospital, all in Jersey City. Dr. Finkelstein was a member of the American Medical Association.

Dr. Robert J. Gross

Word has been received of the death of Robert John Gross, M.D. Born in 1912, Dr. Gross received his medical degree from the University of Zurich Medical School, Switzerland, in 1936. During his career, Dr. Gross was affiliated with the radiology departments of the VA Medical Center, East Orange; St. Mary Hospital, Hoboken; and the Orthopedic Center, Newark. Dr. Gross was a clinical associate professor of radiology for UMDNJ-New Jersey Medical School, Newark. Dr. Gross was a member of the American Medical Association and of our Essex County

component. He was a diplomate of the American Board of Radiology.

Dr. Charles E. Langgaard

A retired member of our Essex County component, Charles Erich Langgaard, M.D., died on May 25, 1988. Born in 1919 in Newark, Dr. Langgaard received his medical degree from Syracuse University Medical School, New York, in 1943. During his 40-year career, Dr. Langgaard was affiliated with Orange Memorial Hospital, Newark Presbyterian Hospital, Lutheran Memorial Hospital, Newark, and Overlook Hospital, Summit. An otolaryngologist, Dr. Langgaard was a member of the American Medical Association, a diplomate of the American Board of Otolaryngology, and a fellow of the American Academy of Ophthalmology and Otolaryngology.

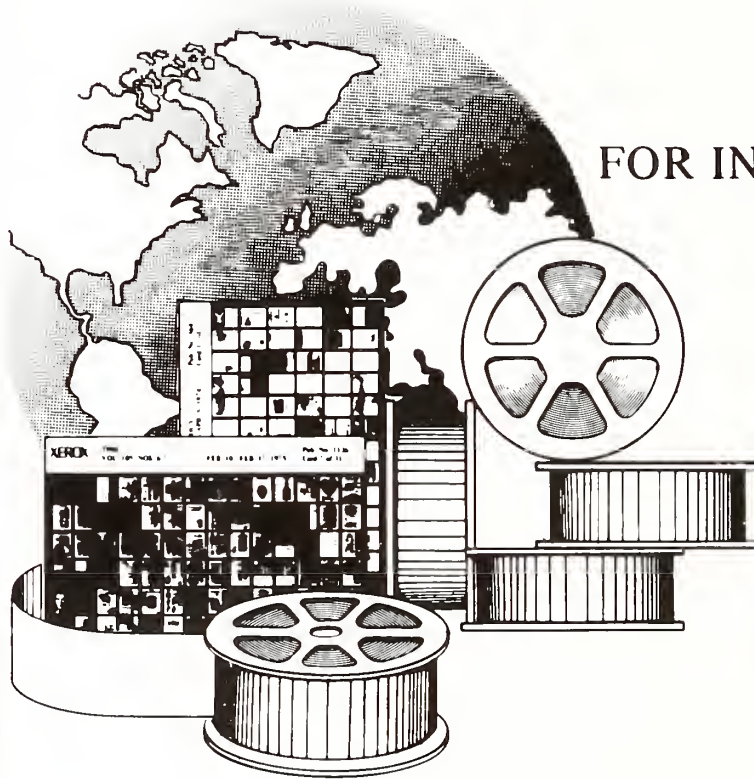
Dr. Max Magnes

Word has been received of the death of Max Magnes, M.D. Born in 1902, Dr. Magnes received his medical degree from University of Washington School of Medicine, Seattle, in 1931. A retired member of our Passaic County component and a member of the American Medical Association, Dr. Magnes was a gastroenterologist affiliated with Barnet Memorial Hospital Center, Paterson.

Dr. John Schaefer

At the untimely age of 50, John Schaefer, M.D., died on August 13, 1988. An obstetrician-gynecologist, Dr. Schaefer received his medical degree from the University of Bologna Medical School, Italy, in 1965. He was a staff physician at Jersey Shore Medical Center, and an associate professor at Robert Wood Johnson Medical School. Dr. Schaefer was a fellow of the American College of Surgeons and of the American College of Obstetricians and Gynecologists, and a diplomate of the American Board of Obstetricians.

This Publication is Available in MICROFORM



FOR INFORMATION
WRITE:

University Microfilms International

Dept. F.A.
300 North Zeeb Road
Ann Arbor, MI 48106
U.S.A.

Dept. F.A.
18 Bedford Row
London, WC1R 4EJ
England

FEBRUARY 1989
VOL 29 NO 2

THE JOURNAL OF MEDICAL CONSULTATION

Consultant



Last month 125,000 of your colleagues learned all this. It took them just 35 minutes.

PEPTIC ULCER AND REFLUX ESOPHAGITIS

- Management for the Long Term
- Barrett's Esophagus: Strategies and Controversies

HYPERTENSION

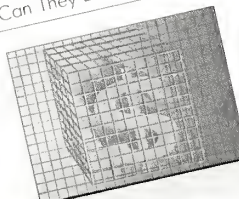
Caring for the Hypertensive Pregnant Patient

HERPES MANAGEMENT

Where Treatment Is Warranted—and Where It Is Not

UNDERINSURED AND UNINSURED PATIENTS

- Who Are They, and How Can They Be Covered?
- Basic Health Care The Washington State Experiment



The age old challenge. How do you keep down the time it takes to keep up to date?

The answer is simple.

You do it with **CONSULTANT**.

CONSULTANT SOLVES THE PROBLEM OF

INFORMATION VS. TIME. Period. The key:

CONSULTANT's unique editorial format—**EVERYTHING YOU NEED TO KNOW, FROM CLINICAL ADVICE TO COST CONTAINMENT**, in a quick, readable, style.

And since **CONSULTANT's** contributors are physician authors, **SOME OF THE BRIGHTEST NAMES IN**

MEDICINE ARE AVAILABLE FOR FREE CONSULTATION.

Such as Henry Black, Yale University School of Medicine; Faith Fitzgerald, University of California School of Medicine at Davis; Dale Murphy, Akron (Ohio) City Hospital; Frank Myers, College of Osteopathic Medicine, Athens, Ohio; David Nash, University of Pennsylvania; Robert Rakel, Baylor College of Medicine; Edward Shahady, University of North Carolina School of Medicine.

THIS MONTH, PICK UP THE INFORMATION YOU NEED. PICK UP SOME TIME GETTING IT. PICK UP CONSULTANT.

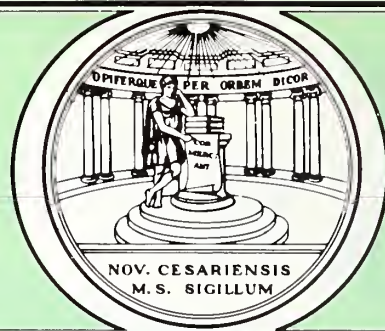
CONSULTANT. Value—cover to cover.

THE JOURNAL OF RESPIRATORY DISEASES • THE JOURNAL OF CRITICAL ILLNESS • THE JOURNAL OF MUSCULOSKELETAL MEDICINE

Consultant

The Journal of Respiratory Diseases • The Journal of Critical Illness • The Journal of Musculoskeletal Medicine
Cliggett Publishing Co. • 55 Holly Hill Lane • Box 4010 • Greenwich, CT 06830 • (203) 661-0600 • (212) 993-0440

MEMBERSHIP NEWSLETTER



THE MEDICAL SOCIETY OF NEW JERSEY

VOLUME 64

FINANCIAL DISCLOSURE LAW Medical Society of New Jersey

S-734 was signed into law and requires physicians and other practitioners to advise patients when they are being referred to a health care service in which the practitioner and/or his immediate family have a financial interest of 5 percent or \$5,000.

Excluded from disclosure requirements would be ownership in a building when space is leased at prevailing straight lease rates or publicly traded securities.

Notice must be made by posting and by handing out the following:

State law mandates that a physician, chiropractor, or podiatrist inform his patients of any significant financial interest he may have in a health care service.

I wish to inform you that I have a financial interest in the following health care services to which I refer my patients:

(list of applicable services)

You may, of course, seek services at a health care service provider of your choice. A listing of alternative providers can be found in the classified section of your telephone directory under the appropriate heading.

Posting should be done in a conspicuous place in the office or waiting room. Handouts need only be given to those for whom the service is ordered.

PROPOSED MEDICAL MALPRACTICE SURCHARGE Medical Society of New Jersey

In August 1988, the insurance commissioner proposed a 5 percent surcharge on the professional liability policies of certain health professionals to fund a \$64.4 million deficit in the government-run Malpractice Association. The hearing officer, appointed by the insurance commissioner to conduct the October 1988 hearing on the commissioner's proposed tax, filed her report in late January 1989.

Her recommendations are that practitioners insured by the Malpractice Association should pay a 5 percent surcharge. That practitioners never insured by it should pay a 2.5 percent surcharge. Health care facilities insured through the Malpractice Association are

to pay a 3.7 percent surcharge, while those never insured should pay 2.5 percent. The surcharges are to run for seven years and would raise \$64 million.

While her suggestions are an improvement, they remain unsatisfactory; the Medical Society of New Jersey and the Medical Inter-Insurance Exchange of New Jersey remain opposed. We are steadfast in the position that those never insured by the Association should not pay any portion of the deficit.

Please do not be lulled by the hearing officer's report. The Department still is proposing to ignore responsibility for its dominant role in creating the deficit. Likewise, the 2.5 percent surcharge against practitioners and hospitals never insured through the Association would raise \$48 million of the proposed \$64.4 million tax.

EYE SURGERY AND OPTOMETRIC FOLLOWUP State Board of Medical Examiners

At its September 1988 meeting, the State Board of Medical Examiners adopted the policy that ophthalmologists are responsible for postsurgical followup and cannot delegate that responsibility to optometrists. In December 1988, at the request of the New Jersey Optometric Association, the Medical Examiners rescinded that policy. The Board of Trustees of the Society wrote to the State Board in January 1989 requesting they reconsider their decision. The Society believes postsurgical followup is the responsibility of the operating surgeon or of a fully licensed physician specifically designated by the operating surgeon.

SECONDARY PAYOR PROGRAMS American Medical Association

If physicians in your state or county are experiencing "secondary payor" problems, please relate the nature and extent of those experiences to Janet Horan (312/645-5538) or Bruce Blehart (312/645-4764), Department of Federal Legislation. This information is needed to document AMA's case for direct Medicare payment to physicians on assigned claims and Medicare carrier billing against the primary coverage party.

FINI

"There are no impossible dreams, only impossible dreamers."

PUBLIC AFFAIRS UPDATE

CLARK MARTIN*

***Financial Disclosure
Becomes Law; Report
Suggests Lower Surcharge;
Structured Verdicts Bill
Loses Ground; Medical
Waste Bill***

FINANCIAL DISCLOSURE BECOMES LAW

Governor Kean's signing into law last month of a financial disclosure bill successfully concluded one of the Society's most interesting legislative battles of the 1980s. The bill, S-734/2091, recognizes a physician's right to own a health care service to which he sends patients—as long as that interest is disclosed to the patient.

The new law developed from the Society's pitched battle against A-2647, the infamous "physical therapy prohibition" bill in the 1986-1987 session. That bill would have prohibited physicians from employing physical therapists or owning facilities, such as cardiac rehabilitation centers, which provide physical therapy services. Proponents of the bill argued that a ban was needed in order to prevent physicians from prescribing unneeded services simply for financial gain. If patients knew about the physician's interest, went the argument, they would go elsewhere. The Society recommended the financial disclosure bill as a means of putting those charges to rest. Such disclosure is recommended in the AMA's code of ethics.

The new law was sponsored by Senators Richard Codey (D-West Orange) and John Russo (D-Toms River). Its Assembly sponsor was Assemblyman Chuck Haytaian (R-Hackettstown).

The law covers physicians as well as other professions regulated by the Board of Medical Examiners (podiatrists and chiropractors), and acknowledges their right to own all types of inpatient and outpatient services. The law specifically mentions, but is not limited to, a bioanalytical laboratory, pharmacy, home

health care agency, rehabilitation facility, nursing home, hospital, radiological and other diagnostic imaging services, physical therapy, ambulatory surgery, and ophthalmic services.

Disclosure is required prior to patient referral if the physician's financial interest exceeds \$5,000 or 5 percent of the facility, whichever is less. The same applies when a member of the physician's immediate family has invested in a facility.

The law requires patients to be given written notification, plus the posting of a disclosure notice in a conspicuous place in the physician's office. The language of the disclosure form, which is specified in the law, will name the facility in which the physician has an interest, and inform patients that the names of other facilities can be found in the classified section of the telephone book.

The new law will be enforced under rules to be adopted by the Board of Medical Examiners.

REPORT SUGGESTS LOWER SURCHARGE

An Insurance Department hearing officer has issued a report which recommends that most physicians pay a 2.5 percent surcharge on their malpractice insurance premiums—half of what originally was proposed—to make up the deficit of the Medical Malpractice Reinsurance Association.

The report of Special Deputy Commissioner Holly Bakke, who presided over a public hearing on the surcharge last October, in effect acknowledges the unfairness of placing so great a bail-out burden on physicians who did not purchase underpriced malpractice insurance from the state-run plan, and thus are not responsible in any way for its deficit. The Medical Malpractice Reinsurance Association sold insurance at bargain-basement prices from 1976 to 1982, despite warnings from private insurers that its premiums were too low to meet projected liabilities. The Insurance Department now is looking for a way to meet an estimated \$64.4 million deficit.

If Insurance Commissioner Kenneth Merin adopts the report's recommendations, hospitals also will be assessed a surcharge. The Department's original proposal, published last August, did not include a surcharge on hospitals.

The report says that physicians who purchased insurance from the Medical Malpractice Reinsurance Association should pay the full 5 percent surcharge as proposed last August, while those who are blameless should pay 2.5 percent. Likewise, hospitals which were insured or reinsured by the Association would pay a surcharge of 3.75 percent. Hospitals which did not participate in the plan would be assessed 2.5 percent.

Bakke's report proposes that the surcharge be collected for seven years. The 5 percent surcharge would yield \$12 million over that period; the 3.75 percent surcharge on hospitals another \$4 million, and the 2.5 percent surcharge on innocent physicians and hospitals \$48 million, for a total of \$64 million.

The Society will continue to fight against the surcharge—in the courts if necessary—using as the basis of its argument strong evidence that the in-

*Mr. Martin is MSNJ's legislative consultant.

insurance commissioner lacks the legal authority to assess physicians who did not participate in the state plan.

The Bakke report emphasizes the wording of a 1975 law which created the Medical Malpractice Reinsurance Association as a reinsurance facility. Its purpose was to make New Jersey more attractive for commercial carriers to sell malpractice insurance by offering them a reinsurance plan through which they could spread their risks.

However, the trouble did not begin until the passage of a 1978 law permitting the state to sell insurance directly to physicians and hospitals. In the Society's view, the language of that 1978 law clearly prohibits a surcharge on nonparticipating physicians.

The Bakke report is completely silent on the 1978 law, as if it did not exist. Ironically, if it had not been for that law, the \$64.4 million deficit would not exist.

STRUCTURED VERDICTS BILL LOSES GROUND

A major tort reform bill which was poised for passage in the Senate just a few weeks ago now is in serious trouble following its referral back to committee by its sponsor, Senator Raymond Lesniak (D-Elizabeth).

S-1845, the "structured verdicts" bill, is intended to bring cost containment to medical malpractice cases. It would require judgments for future damages over \$250,000 to be paid in installments over time, rather than as a lump sum. Past damages, such as medical expenses and lost income, still would be paid at settlement.

If enacted, the bill would permit the Medical Inter-Insurance Exchange of New Jersey (MIENJ) and other malpractice carriers to operate with reduced cash reserves, and thus would pave the way for perhaps an 8 percent reduction in premiums.

Enactment of a "structured verdicts" law has been the top priority of MIENJ for several years. Its Trenton lobbying firm is responsible for shepherding the bill through the Legislature, while the Society assists with lobbying in Trenton and at the grassroots. Also assisting are the Hospital and Dental Associations. By all counts, it appeared that the bill had sufficient votes for passage in the Senate before it was returned to the Judiciary Committee.

Two powerful trial attorney lobbies, LEGAL and ATLA, are vigorously working against passage of the bill with the assistance of the Bar Association. While they are raising arguments against "structured verdicts" being unfair to plaintiffs, their opposition fundamentally is economic.

Under contingency fee rules adopted by the State

Supreme Court, a plaintiff's attorney receives a portion of the amount awarded at settlement. Thus, if future damages are awarded in a lump sum, the attorney benefits. But if those damages are structured as a gradual payment, the attorney receives only a portion of the price of the annuity that will provide the periodic payments. That's a lot less.

Moving S-1845 out of the Judiciary Committee and back to the floor of the Senate will be difficult and time-consuming, but not impossible. MIENJ's lobbyist currently is working to firm up the support which S-1845 had when it was released from that committee last June.

MEDICAL WASTE BILL

A medical waste tracking bill which has undergone six major revisions in its journey through the Legislature has been sent to Governor Kean for his signature.

While the Governor may recommend some changes of his own, there is no doubt that S-2343/A-2853 eventually will become law and, for the first time, will introduce a uniform statewide procedure for handling medical waste.

If Governor Kean signs the bill as is, it will take effect this month and will govern physicians, dentists, veterinarians, podiatrists, and a host of facilities ranging from hospitals to laboratories.

The law will require practitioners and facilities to register as "generators" with the Department of Environmental Protection and contract with approved haulers to pick up medical waste. They, in turn, will be monitored to assure that the waste is taken to approved facilities.

Although the law is simple in concept, undoubtedly there will be a number of wrinkles to be ironed out before the system operates efficiently. The major problem is the state's lack of sufficient landfill space and incinerators for proper disposal.

The law will apply to such medical waste as blood vials, cultures, pathological waste, blood and blood products, hypodermic needles, syringes, and sharps.

Physicians and other "generators" will be required to fill out a manifest which will accompany the medical waste when it is picked up. The manifest will be the same as that required under the soon-to-be-implemented federal medical waste tracking law.

We estimate that it will take at least a year for the major elements of the program to be set in place. Every physician will receive detailed information about his responsibilities from the Departments of Environmental Protection and Health.

Tort Reforms

Notes on Tort Reforms Enacted in Other States

The Medical Society of the State of New York recently completed the following update on tort re-

form in other states.

Arizona. The state constitution (in two separate areas) prohibits liability limits. Abolition of joint liability concept; medical review panels required prior to court action; collateral source information may be introduced but offset is not mandatory; standard of care defined in statutes.

California. A \$250,000 cap on noneconomic damages and other major tort reforms, including: collateral sources of income admissible as evidence; periodic payment for future damages exceeding \$50,000; provisions for arbitration of claims; shortened statute of limitations; and a sliding schedule for attorneys' contingency fees starting at 40 percent of the first \$50,000, 33⅓ percent of the next \$50,000, 25 percent of the next \$100,000, and 15 percent of any amount exceeding \$600,000. These measures were enacted in 1975, when premiums in California were higher than in New York. California premiums now are sharply lower than premiums in New York. Highest premium: \$92,800. Average premium: about \$8,000.

Colorado. Cap of \$1 million on total damages, including an absolute \$250,000 cap on noneconomic damages; cap may be pierced for present value of future wage loss or health care cost; introduction into evidence of payments from collateral sources; elimination of joint and several liability; punitive damages limited to three times net pecuniary loss; mandatory periodic payment of all future damages exceeding \$150,000; mandatory liability insurance; voluntary

binding arbitration; statute of limitation two years, statute of repose three years. Highest premium: \$53,000. Average: \$12,500.

Florida. Cap of \$450,000 on noneconomic damages; regulation of insurers; periodic payment on awards greater than \$5,000 and sliding scale of contingency fees for plaintiff attorneys; offset collateral sources against damages; limitation on joint and several liability; penalties for frivolous suits and defense; certificate of merit; mandatory presuit investigation by the parties; voluntary binding arbitration; no-fault birth-related neurological injury compensation system; and good Samaritan immunity for emergency room medical treatment.

Georgia. Allows awarding of costs and fees in frivolous suits; contingency fees regulated and limited to plaintiff attorneys. A minor shall have two years from his/her fifth birthday to file a medical malpractice suit or five years from the date of the negligent act or omission if the minor was age five or older when the act of omission occurred. Except for gross negligence or willful misconduct, health care providers shall not be liable for injuries arising out of voluntary charity work done at the request of a hospital, public school, nonprofit organization, or government agency. Highest premium: \$70,800. Average premium: \$17,500.

Illinois. Structured verdicts; contingency fee limitations; abolition of punitive damages; collateral sources reduce award; itemized verdicts; expert witness rules; early dismissal of uninvolved physicians.

Indiana. A \$500,000 overall cap; physician liability limited to \$100,000; allows collateral payments to be introduced into evidence. The first \$100,000 comes from carrier and for additional \$400,000, an application is made to the patient compensation fund. Highest premium: \$11,500 for \$100,000 cover. \$11,500 plus 125 percent surcharge to finance the patient compensation fund.

Iowa. Limitations on joint and several liability; expert witness qualifications; damage awards may not include payment from collateral sources; sanctions for "groundless" suits; periodic payment of future damages. Highest premium: \$50,100. Average premium: \$19,500.

Kansas. A cap of \$250,000 on noneconomic damages; itemized verdicts; expert witness qualifications; court approval of attorneys' fees; mandatory liability insurance as a condition of licensure; pretrial settlement conferences; costs and fees awarded in frivolous claims or defenses; collateral sources may be used to offset damages. Highest premium: \$68,000.

Kentucky. Modification of joint and several liability rule; punitive damages guidelines; introduction into evidence payments from collateral sources; certificate of merit; court review of adequacy of award; penalties for frivolous lawsuits.

Louisiana. A cap of \$500,000, excluding hospital and medical care and lost wages.

Maine. Sliding scale for attorney's fees; periodic payment of future damages; pretrial screening panels;

*This item from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are Director of the Department and Director of Special Projects.

shortened statute of limitations; regulation of contingency fees effective July 1, 1988.

Maryland. Cap of \$350,000 on noneconomic damages in all personal injury actions; periodic payment of future damages; itemized verdicts; expert witness qualifications; certificate of merit; regulation of contingency fees.

Minnesota. Increased regulation of insurers; certificate of merit; shortened statute of limitations for minors; mandatory offset of collateral sources against damages; judicial hearing prior to claiming punitive damages; allows awarding of costs and fees where there is a frivolous claim or defense; itemized verdicts; cap to \$400,000 for intangible loss in all civil actions—intangible loss is defined as embarrassment, emotional distress, and loss of consortium, but does not include pain and suffering. Periodic payment of future damages; modification of joint and several liability rule.

Mississippi. Award of costs and fees where there has been a frivolous claim or defense. Highest premium: \$110,900 (\$5 million/\$5 million coverage). Average premium: \$11,100.

Missouri. A cap of \$350,000 per defendant on noneconomic damages; periodic payment of future damages; modification of joint and several liability; mandatory liability insurance of \$500,000 as a condition of hospital staff privileges—only applies in counties with a population in excess of 75,000; itemized verdict; certificate of merit.

Nebraska. Overall cap of \$1,000,000.

New Hampshire. Shortened statute of limitations; cap of \$875,000 on noneconomic damages in all personal injury actions; court must approve attorney's fees when settlement or verdict exceeds \$200,000; prohibits punitive damages; penalty for frivolous suits.

New Jersey. Mandatory nonbinding arbitration of claims below \$20,000; damage awards offset by collateral sources of income; modification of joint and several liability; assessment of costs and fees to party making a baseless pleading. Highest premium: \$42,000. Average premium: \$13,400.

New Mexico. A cap of \$500,000, but provides for all past and future medical needs related to the cause of action; caps on physician liability.

Ohio. A cap of \$200,000 on noneconomic damages; collateral sources may be used to offset damages.

Oregon. A \$500,000 cap on noneconomic damages; significant modification of joint and several liability rule; higher standard of proof for punitive damages; immunity from punitive damages for health care professionals except where actions are willful or wanton; countersuits and penalties for frivolous lawsuits; some collateral source offsets.

Rhode Island. Awarding of costs and fees in frivolous suits; collateral sources admissible as evidence; periodic payment of future damages must be considered; medical liability insurance is required.

South Carolina. Shortened statute of limitations for minors; punitive damages guidelines; award of costs and fees where there has been a frivolous claim or defense; limited liability for state-employed physicians.

South Dakota. Cap of \$1,000,000 on total damages;

periodic payment of future damages; judicial hearing prior to submission of issue of punitive damages to jury; allows awarding of costs and fees to defendant in frivolous lawsuits; shortened statute of limitations for minors; punitive damages guidelines; limited liability for state-employed physicians.

Texas. Limitations on joint and several liability; punitive damage restrictions; sanctions for frivolous lawsuits; exemption from personal liability for physicians performing duties under contract to Texas Health or Corrections Departments or Youth Commission; reduced liability for voluntary service to charitable organizations. Highest premium: above \$50,000. Average premium: \$10,650.

Utah. A cap of \$250,000 on noneconomic damages; periodic payment of future damages; elimination of joint and several liability; mandatory offset of awards for collateral sources of income; attorney contingency fee limitations; shortened statute of limitations for adults and minors; guidelines for establishment of a Joint Underwriting Association; pretrial screening panels; elimination of "ad damnum" clause.

Virginia. Overall cap of \$1,000,000; pretrial screening; shortened statute of limitations; no-fault compensation system for birth-related neurological injury cases.

Washington. Sliding scale cap for noneconomic damages based on life expectancy (assumes minimum life expectancy of 15 years); minimum/maximum awards of \$117,000 for those damaged later in life and \$573,000 for damages at birth; periodic payment of future damages; shortened statute of limitations; modification of joint and several liability rule.

West Virginia. Cap of \$1,000,000 on noneconomic damages; increased regulation of insurers; shortened statute of limitations; elimination of "ad damnum" clause; expert witness qualifications; modification of joint and several liability effective at the 25 percent level.

Wisconsin. A cap of \$1,000,000 on noneconomic damages; itemized verdicts; sliding scale for attorney's fees; mandatory nonbinding mediation (replaces pretrial hearing; reduction of all future losses to present value, with payment at the time of award; shortened statute of limitations.

Wyoming. Assessment of costs and fees to party making baseless pleading; affidavit of noninvolvement (allows early dismissal of defendant); elimination of joint and several liability.

Eleven states have adopted statutes allowing voluntary and binding arbitration in malpractice cases. Patients who do not sign arbitration agreements may not be denied treatment or otherwise be discriminated against. The laws allow a revocation period by the patient (usually 30 to 60 days) following treatment. The 1986 New York legislation provided for arbitration on a pilot basis in the HMO setting, and in certain cases where the defendant concedes finality.*

*The Medical Society of New Jersey would like to thank Edward A. Hynes, APR, Stephen L. Davidow, Manager, Media Relations, and the Medical Society of the State of New York for their help in putting this material together.

The Mantle of Leadership

PALMA E. FORMICA, M.D.

The Annual Meeting of the Medical Society of New Jersey will be held April 27 to April 30, 1989.

During the last week of April, the Medical Society of New Jersey will hold its 223rd Annual Meeting. There are 394 delegates to the House representing 21 county societies, 14 specialty societies, a medical student section, and all residents.

This is a convocation of the leaders of organized medicine. It is a demonstration of democracy in action. Any member can prepare a resolution to present to the House, can have it discussed at a reference committee, and can have it voted on by the House of Delegates. The policies of the Medical Society are made in the House of Delegates.

Officers, trustees, and AMA delegates and alternates are elected by the House. Even though there are recommendations by the Nominating Committee, anyone can run from the floor and get elected. Those of us who did run from the floor know it is possible.

Every single delegate wears the mantle of leadership. Every delegate has the power to make change happen. Those who have been elected by their constituencies have the responsibility to be present at the delibera-

tions and to make his vote count. It is easy to say, "What have you done and why did you let this happen?" You can be a policymaker!

Several years ago, there was an impassioned plea for more funds for public relations. The House of Delegates, after weighing the pros and cons, voted for a special assessment. This was not received with enthusiasm, and generated some hostility from those who believed it was a unilateral and unwarranted decision of the officers and the Board of Trustees. It was the will of the House of Delegates; and, as such, it was a directive to be carried out. I understand there will be a resolution presented this year requiring more than a simple majority to approve such assessments.

In 1987, the House of Delegates came back home to New Jersey. With such a large House, finding a place to accommodate the group has been difficult. Few of the hotels in Atlantic City could or would guarantee sufficient space for the Annual Meeting. The Committee on Annual Meeting has a thankless task, but does an excellent job. Last year, the meeting was fairly well attended with 333 delegates present.

Because of expressed interest by our membership, the scientific aspects of the Annual Meeting are being expanded. On Thursday afternoon, there will be two educational sessions preceding the reference committee meetings. The seminar on Sunday will deal with environmental concerns for the physician and the private citizen. All of these have CME credits at no cost.

I encourage those of you who are not members of the House of Delegates to attend the scientific sessions and to stay to see a reference committee in action. It is like an open town meeting where any member can speak, ask questions, or present his views on a topic. After the open meeting, the reference committee makes recommendations to the House of Delegates. The voting delegates may accept, reject, or modify the resolutions. Frequently, many resolutions passed by the House of Delegates are forwarded to the AMA House for action on a national level.

The Hospital Medical Staff Section operates in a different manner. Delegates from individual hospitals representing their medical staffs convene on a state-wide level and have input directly at the state and national level. Thus, participation is open both from the counties and the individual hospitals.

Access to participation and decision making is open. Everyone (medical students and residents included) has the opportunity to affect the direction of the profession.

Power—the ability to influence decisions—is in your hands. Use it!

We're putting lives back together.

As a physician you've probably seen it. A family's struggle against alcohol or drugs. A man or woman afraid to ask for help in dealing with depression. A young girl hiding an eating disorder behind a smiling face or popular personality.

At the Carrier Foundation, we work with physicians in treating troubled adolescents and adults. Unlike most general hospitals, all our resources are dedicated to this mission. And have been for more than seventy-five years.

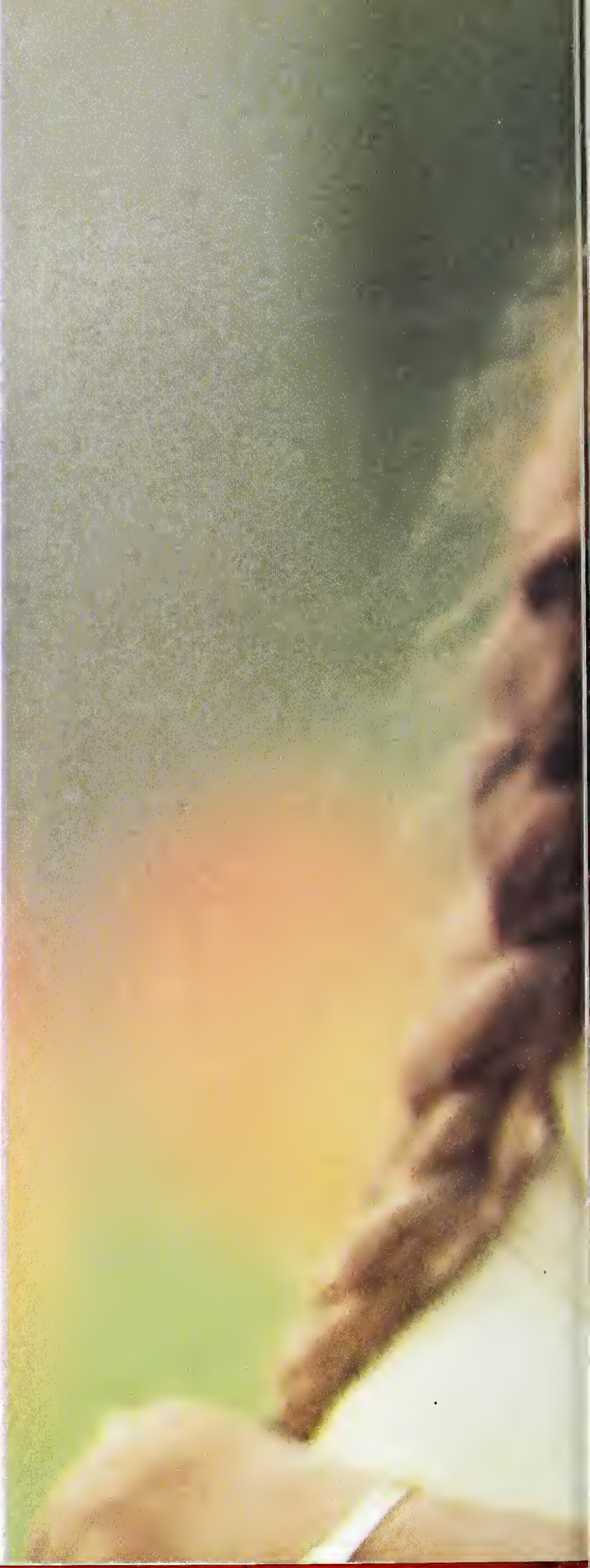
Recognized by all major insurance companies, Carrier is a private, non-profit psychiatric hospital providing both inpatient and outpatient programs. Some of Carrier's specialized programs include: addiction recovery service, adolescent program, affective disorders program, behavioral therapy, eating disorders program, family therapy, geriatric program and women's program.

For more information, call the Carrier Foundation at 1-800-223-0207. The Carrier Foundation. We're putting lives back together.



Carrier Foundation

Belle Mead, New Jersey 08502



Quality of Care and Quality of Caring

HOWARD D. SLOBODIEN, M.D.

The pervading struggle during the past decade with cost containment is yielding part of the stage to considerations of quality of care and the evaluation of the performances of health care providers. But the activities of the past already have impacted severely on what is more important—the quality of life.

Much of the discussion on the quality of life has centered on the ethical considerations of withholding treatment in those severely impaired by congenital defect or by the ravages of life-threatening illness. Too little has been said about the reduction in the comforts of living in those seen in day-to-day medical practice.

Not too many years ago, criteria were mandated regarding the admission, treatment, and discharge planning of hospitalized patients; 100 percent compliance was expected. Those days are gone. Can you imagine, today, insisting that a postoperative hernia patient have normal bowel function before discharge? What happened to the trim points in DRGs that were supposed to represent reasonable lengths of stay?

In 1982, we warned that patients were being discharged prematurely, the “quicker and sicker” phenomenon. Nothing has changed. The home health care agencies still find it difficult to give the required level of care and nursing homes are seeing higher mortality rates in patients recently discharged from acute-care hospitals. We now have documentation of a lowered ability of certain groups of patients to return to functional levels. Premature discharge carries the twin dangers of failure to diagnose and failure to treat.

We have participated in many cost-cutting measures in recent years; witness the explosive increase in the numbers of one-day surgery cases. There is very little fat left in the system and insistence on same-day or next-day discharge can inflict cruel and unusual punishment on too many people.

All patients are affected, although problems are more

apparent in those with surgical conditions. Much mischief has been done, and perpetuated, by the pernicious acceptance of the terms “necessary” and “unnecessary.” Very little surgery is truly “necessary,” except for operations to preserve or conserve life; we should dispense with these terms.

Between the extremes of “necessary” surgery—to save life—and cosmetic surgery lies the bulk of the surgical population in need of “indicated” surgery, deliberately scheduled and designed to enable people to read a newspaper, have a decent night’s sleep without going to the bathroom five times, or take a brisk walk without pain and swelling in the groin.

Those espousing managed health care must be shutting their eyes to these and other truisms. As people live longer, they have more chances to develop problems. As more people receive insurance coverage, they seek care more frequently. These are facts and the desires of business, industry, insurance companies, and the government to decrease the frequency of care in the interests of cost conservation, of necessity, must interfere with the quality of life for many Americans.

Fee-for-service practice has received much adverse criticism, e.g. for being a cottage industry with built-in incentives to increase the volume of work. But it is totally in harmony with the American tradition of free enterprise, although it may be inimical to the socialistic dreams of bureaucracy. If consideration for both the purse and the patient is needed, what group is better qualified to render honest judgments than medicine, still recognized as the profession with the highest standards of morality?

Managed health care programs offering incentives to deny care are an abomination; they have existed unwisely and should be banished to those countries of pinkish hue that seem to care too little for the quality of life of their ailing citizens.

The plan of the AMA to join with the RAND corporation in setting clinical guidelines to identify appropriate care is a new and interesting development. It is conceded by Dr. John Kelly, director of the AMA Office of Quality Assurance, that these guidelines “may raise concerns that their use could limit medical innovation ... and result in payment denials for unnecessary medical care.” This plan was applauded by the Physician Payment Review Commission as another potential means of reducing so-called inappropriate or marginally beneficial procedures. Have we forgotten the misguided efforts to ration CT scans and other advances in health care? Are we to stifle scientific strides?

Finally, we must stop arguing about the health care industry and the percentage of the gross national product it swallows. Our viability and our ability to give quality care in all respects to our patients should certainly be as important as the health of the beauty product or the automobile industries. Ominously, the ratio of applicants to acceptances at American medical schools continues to decline. Those admitted still possess the high qualifications seen through the years; should this change because of the decreasing attractiveness of medicine as a profession, the standard of health care in this country will become mediocre indeed, given the other forces that are lowering the common denominator. Caveat emptor.

When it comes to your patients' health leave no stone unturned.



Lithotripsy at

The New Jersey Kidney Stone Treatment Center can be the alternative.

Convenience—The New Jersey Kidney Stone Treatment Center is centrally located in downtown New Brunswick, near major highways, for easy access for you and your patients.

Flexible scheduling—The Center offers scheduling with no delay. In most cases, your patient can be treated within a week of your call. Our extended hours allow you to make appointments at the convenience of both you and your patients.

Bath-free equipment—The Center is equipped with the most advanced Dornier HM4 lithotripter, eliminating the need for a water bath, allowing for easier patient handling and greater patient comfort. Also in use is a state-of-the-art Shimazdu Hydrojust III cystoscopy table.

Experienced, professional staff—The staff of the New Jersey Kidney Stone Treatment Center is well-versed in lithotripsy treatment, and includes board-certified Anesthesiologists, critical-care trained nurses and skilled lithotripsy technicians.

Physician billing—Urologists treating patients at the Center have the advantage of billing their patients or third-party payers directly through their own offices.

Easy referral system—If desired, physicians can easily refer their patients to one of our staff Urologists for lithotripsy treatment.

HMO eligibility—The Center has established arrangements with most major area HMO's.

For more information regarding how the Center can help you and your kidney stone patients, call 1-800-542-8887 or (201) 937-8614.

New Jersey Kidney Stone Treatment Center

**Located at Robert Wood Johnson University Hospital
New Brunswick, New Jersey 1-800-542-8887**

The New Jersey Kidney Stone Treatment Center is operated by Health Horizons (ESWL), L.P., affiliated with the following hospitals: Community Memorial Hospital, Freehold Area Hospital, Helene Fuld Medical Center, Jersey Shore Medical Center, Raritan Bay Medical Center, Riverview Medical Center, Robert Wood Johnson University Hospital, St. Francis Medical Center, St. Peter's Medical Center, Somerset Medical Center.

FOR-PROFIT SMOKING-CESSATION PROGRAMS AND THEIR CLIENTS

RONALD L. CAPLAN, PH.D., MICHAEL GREENBERG, PH.D., LISA BELLET, M.P.H., NEW BRUNSWICK*

We examined the availability of smoking-cessation programs to New Jersey's disadvantaged and minority smokers. Because of their cost and location in affluent white areas, these programs fail to adequately serve this population.

Cigarette smoking is declining in the United States. Over the past 20 years, 35 million adults have stopped smoking.¹ Most smokers quit on their own, but many commercial smoking-cessation programs are available to those seeking professional help.² Is this assistance available to those who are relatively poor and/or black—two of the problem groups of smokers?^{3,4} To answer this question, we examined the development of this industry in New Jersey over a ten-year period.

METHOD

We located smoking-cessation programs by municipality from the local telephone page listings under "Smokers' Information and Treatment Centers" for even-numbered years between 1976 and 1986 inclusive. Although not every business advertises in these pages, telephone books were the only consistently available source of data over the decade.⁵

Because smoking-cessation programs are commercial enterprises, we expected the programs to be disproportionately located in communities whose populations have higher-than-average incomes. Moreover, we expected the residents of these towns to be professionals and managers, and few were expected to be black. If our hypothesis is correct, then smoking-cessation enterprises should be located in communities that

are more affluent and white than the state as a whole, or the county in which the community is located. The null hypothesis states that half of the smoking-cessation programs should be in towns more affluent than the surrounding county and half should be in poorer communities. The difference was evaluated by the Z statistic. For example, assume there are programs in 20 towns, and 11 of the 20 programs are in towns with incomes higher than their host county. Using a significance of $P = .05$, we would accept the null hypothesis that the observed proportion (.55) is not statistically different from the expected (.50). We would reject it if 18 of the 20 were in towns more affluent than their host county.

We collected socioeconomic data at the state, county, and municipal levels from the 1980 *Census of the Population and Housing for New Jersey* because 1980 is the approximate midpoint of our study period. Our variables were: percentage of black citizens, median family income, percentage of persons 25 years and older with four or more years of college, and percentage of persons employed in professional or managerial oc-

*Drs. Caplan and Greenberg are affiliated with the Department of Urban and Community Health, Rutgers University. Ms. Bellet is affiliated with the graduate program in public health, UMDNJ-Robert Wood Johnson Medical School. Correspondence may be addressed to Dr. Caplan, Rutgers University, Lucy Stone Hall, B259, New Brunswick, NJ 08903.



Figure 1—Smoking-cessation programs in 11 communities in New Jersey in 1976.

cupations. For each period, we compared the four variables (race, income, education, and occupation) associated with each program location to the county and state statistics.

Because owners of small businesses cannot always be sure of the most profitable location, businesses often are in or near the owner's home.⁶ To determine what smoking-cessation program owners knew about site selection and to learn about their programs, we telephoned all 25 of the existing programs and conducted 19 interviews, speaking with 17 program directors and with two administrative assistants. The average interview included 12 questions and lasted approximately 15 minutes. The four main areas of inquiry were program design, results, costs, and clinic location.

RESULTS

In 1976, 9 of the 11 programs listed were in the relatively affluent northern half of New Jersey and clustered near New York City. The other 2 programs were in southern New Jersey near Philadelphia (Figure 1). In 1986, 22 of the 25 programs were in northern New Jersey; most clustered near New York City. Of the remaining 3 programs, 2 were in a retirement/resort area along New Jersey's Atlantic Ocean shore and 1 program was outside Philadelphia (Figure 2).

The hypothesized associations become stronger during the study period. In 1976, seven out of nine host

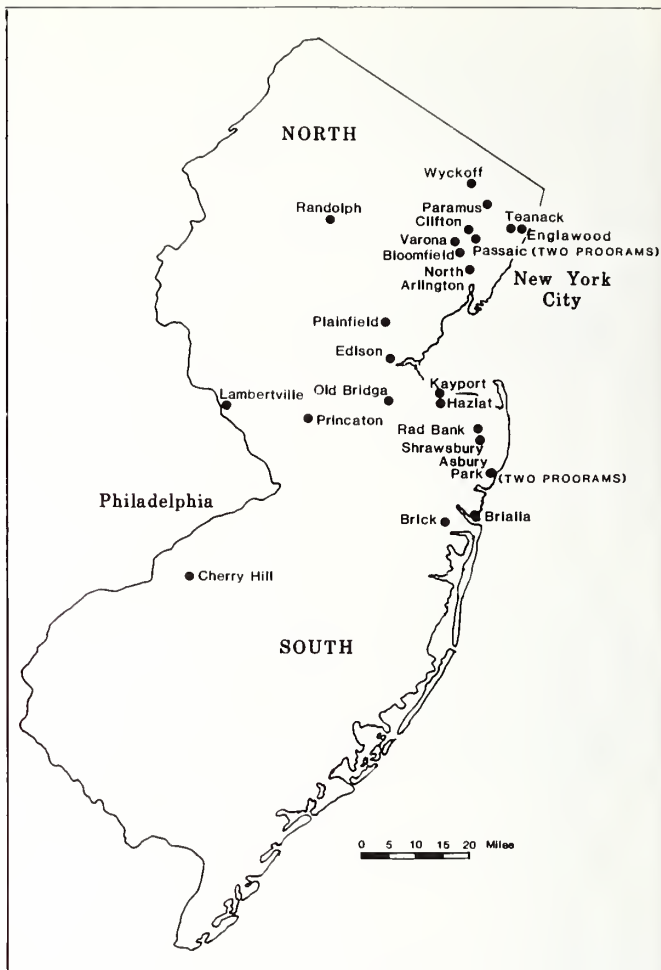


Figure 2—Smoking-cessation programs in 25 communities in 1986.

communities had family median incomes greater than the New Jersey average, as did six out of nine host communities at the county level. Six out of nine communities had more college graduates and professionals/managers than the state average. The corresponding figures at the county level were five and four, respectively. Five of the nine host communities had fewer blacks at both the state and local level. However, none of these were statistically significant at $P = .05$. In 1978, programs were disproportionately located in affluent and white population areas.

By 1986, this trend toward program location in affluent and white population areas was more obvious. For example, 15 out of 23 programs were in communities with incomes higher than the host county ($P = .058$), while 16 of these programs were in communities with a higher percentage of whites ($P = .029$). When compared to the state, the corresponding figures were 17 ($P = .012$) and 18 ($P = .004$), respectively, in relatively affluent and white communities. In short, in 1978, 1980, 1982, 1984, and 1986, smoking cessation programs that advertised in the phone books were likely to be in affluent and white areas, not in poor and/or black ones. With few exceptions, New Jersey's limited public transportation makes these areas accessible to New York and Philadelphia, but not to other New Jersey cities, where the vast majority of poor live.

The interviews revealed that three-quarters of the programs were for-profit businesses. The most fre-

quently cited reason for program location was proximity to the principal therapist's home. No one suggested that our four socioeconomic variables had any connection to the program's location. All owners thought they had good locations: 89 percent of those interviewed believed that their businesses could "easily" expand at their current locations. They were not going to locate in an area with poor people. In the words of one program director, "We're not altruistic. We do it to make money—we're a business and have to go where the money is."

The average total price of a program was \$270. Nearly three-quarters of the programs received no health insurance reimbursement. Most bills were paid either out-of-pocket or by corporate employers. Thus, cost and location probably deter the poor.

DISCUSSION

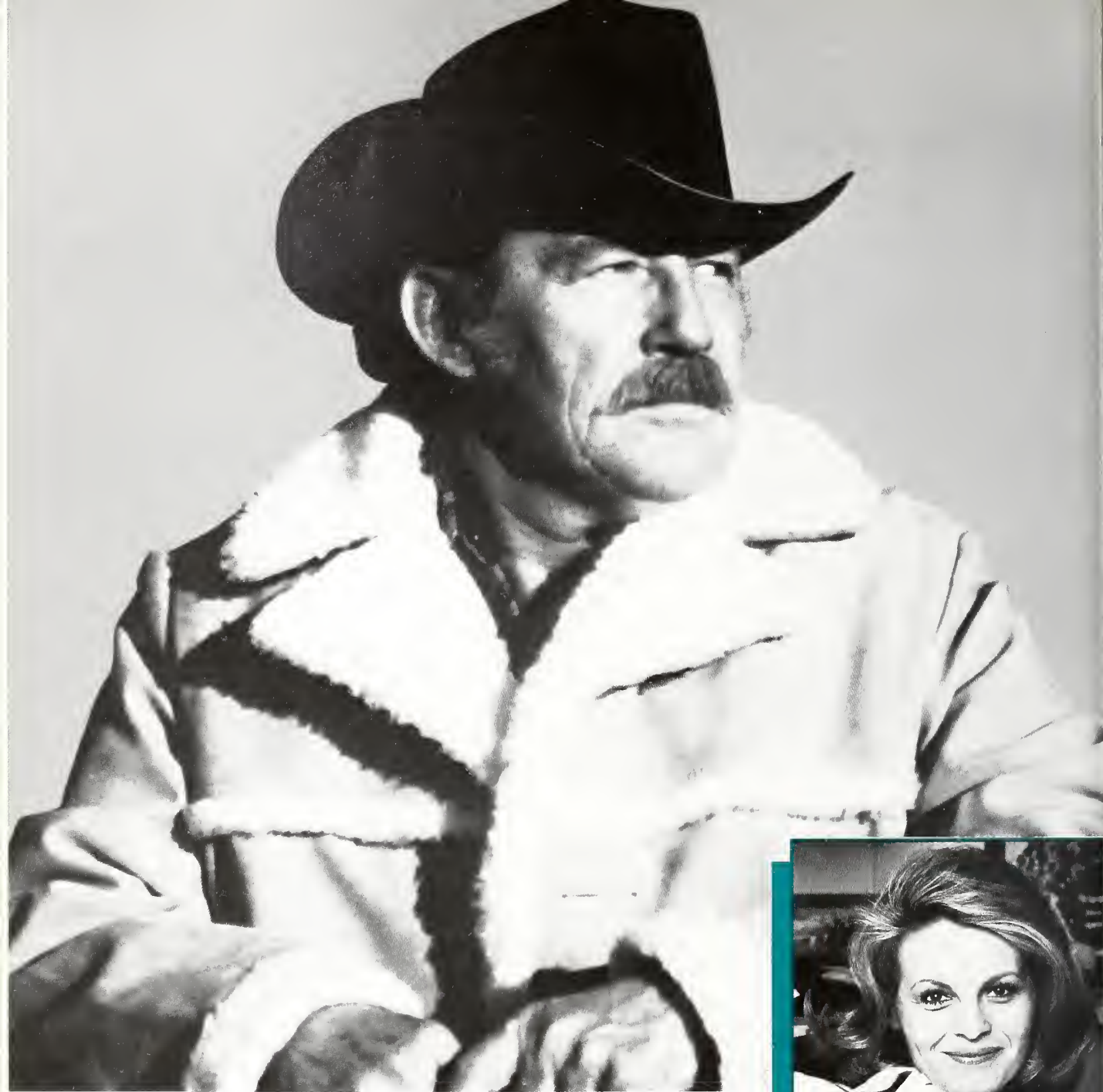
Nationally, nearly 1,000 adult smokers die each day of a cigarette-related illness; about 4,000 more adult smokers quit. From the tobacco industry's viewpoint, smoking must continue. Most of the new recruits are teenagers, many from relatively poor families, or black adults.⁷ In New Jersey, cigarette smoking has decreased in every age group but teenagers. According to the New Jersey State Commission on Smoking or Health, 40 percent of New Jersey's high school students have tried cigarettes, and 20 percent smoke daily.⁸ Only a third of all adults smoke, but half of all blue-collar workers do, and blacks are represented disproportionately.

We conclude that the free market for smoking-cessation services, in New Jersey at least, will not meet the needs of all smokers. John Slade, M.D., chairman of New Jersey's State Commission on Smoking or Health, concluded that this industry "focuses only on those

who can pay out of pocket and does not have a large role in public health strategies."⁹ Minorities and the relatively poor need programs targeted at their particular situations. In New Jersey and ten other states, the National Cancer Institute has funded the Community Intervention Trial (COMMIT). This trial will compare smoking-cessation rates among heavy smokers in two communities, one with and one without a broad-based smoking control program. The New Jersey communities involved in COMMIT, Trenton and Paterson have the highest minority populations of any city in the trial. Such studies will lead to more effective smoking control efforts. Physicians in New Jersey should strongly support these efforts; the free market alone will not suffice.

REFERENCES

1. Remington PL, Forman MR, Gentry EM, et al: Current smoking trends in the United States. *JAMA* 253:2975-2978, 1985.
2. Flay BR: Mass media and smoking cessation. *Am J Public Health* 77:153, 1987.
3. Pederson LL, Lefcoe NM: Change in smoking status among a cohort of late adolescents: Prediction and explanation of initiation, maintenance, and cessation. *Int J Epidemiol* 15:519-527, 1986.
4. Cigarette smoking among blacks and other minority populations. *MMWR* 36:404-408, 1987.
5. Schwartz JL: *Review and Evaluation of Smoking Cessation Methods: The United States and Canada, 1978-1985*. Washington D.C., National Cancer Institute, 1987.
6. Nourse H: *Regional Economics*. New York, NY, McGraw-Hill, 1968.
7. R.J. Reynolds targets teens with sophisticated marketing campaign. *Tobacco Youth Reporter* 2:1, 1987.
8. New Jersey Department of Health: *Preventing Tobacco Dependence in Children: A Report of the of the Commission on Smoking or Health*. Trenton, NJ, 1987.
9. Slade J: Interview. St. Peter's Medical Center, New Brunswick, NJ, 1987.



Dosing Flexibility

Android[®] / 5^{Buccal} / 10^{mg} / 25^{Oral} / 25^{mg}

Methyltestosterone U.S.P. Tablets

Android[®] / F

Fluoxymesterone U.S.P. Tablets, 10 mg.



For Full Prescribing
Information
Please See PDR

THE IMPORTANCE OF DOCUMENTATION IN PEER REVIEW

DAVID I. KINGSLEY, M.D., EAST BRUNSWICK*

The PRO bases its decisions regarding quality of care, medical necessity, and appropriateness of setting upon review of the patient's medical record. Therefore, adequate documentation is essential.

Physicians can minimize the number of issues raised by The Peer Review Organization (PRO) of New Jersey, Inc., by thoroughly documenting their treatment of Medicare patients. The PRO bases its decisions regarding quality of care, medical necessity, and appropriateness of setting upon review of the patient's medical record. It is our experience, as well as PRO experience nationwide, that the majority of PRO questions initially asked of physicians never would be raised if there were adequate documentation.

PRO physician advisors examine several key areas when they perform medical record review. They read the patient's history to see what the rationale was for admission, the physical examination for an assessment of the severity of the patient's illness or injury, and the physician's overall treatment plan for the patient. Progress notes are reviewed for documentation of both routine and unusual occurrences. PRO physician advisors look at the medical record to see that any abnormal laboratory, x-ray, EKG, and/or physical findings are adequately acknowledged and addressed in a timely manner. The discharge summary is assessed for the appropriateness of support and caregiver arrangements, the functioning level of the patient, and details of the patient's diet and medication, as well as plans for followup visits with the attending physician.

Since the federal government's Prospective Payment System (PPS) went into effect in New Jersey on January 1, 1989, The PRO has been given a new area to review in terms of documentation. We now are required to monitor adherence to the physician attestation procedure. This procedure was established by the government for two major purposes: to assure the most accurate and complete clinical information for DRG assignment, and to minimize the possibility of fraud and negligence in the provision of DRG billing information. It is important to realize that physician attestation has been in place in the rest of the country since 1984.

There are two steps involved in physician attestation:

1. *Acknowledgement of Penalty Notice.* A yearly signed acknowledgement by the physician that he has been made aware of the penalties associated with the premeditated misrepresentation of diagnostic and procedural information in the medical record. This note states, in essence, that under PPS, the Medicare payment to hospitals is based, in part, on each patient's principal and secondary diagnoses and major procedures performed as attested to by the attending

*Dr. Kingsley is president, The PRO of New Jersey, Inc. Correspondence may be addressed to Dr. Kingsley, The PRO of New Jersey, Inc., Brier Hill Court, Building J, East Brunswick, NJ 08816.

Documentation Suggestions*

Recording the following items when appropriate will improve The PRO physician advisor's understanding of the case and in many instances, may save attending physicians unnecessary paperwork.

On Admission

1. Include in the history:
 - Reason for admitting now versus outpatient observation or home care
 - Discussion of how outpatient therapy failed
 - Reasons why problems were not resolved during previous recent admissions for the same diagnosis
2. Include in the physical:
 - Vital signs
 - Assessment of distress, acuteness, and severity of illness
 - Description of patient's frailty, dependency, or dementia
3. Describe in general terms your *plan* for this admission, discussing reasons for any limited treatment plan.

In Progress Notes

1. Address and acknowledge any unexpected laboratory and x-ray findings and untoward events or contradictory allied health observations.
2. Explain thinking behind major changes in diagnostic efforts and therapy.

At Discharge

1. Designate the principal diagnosis which is that condition established after study to be chiefly responsible for occasioning the admission to the hospital. Also designate the secondary diagnoses which are all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay.
2. Discuss abnormal laboratory, x-ray, and nursing observations.
3. Note tests not reported at time of summary.
4. In the disposition section describe:
 - Support and caregiver arrangements
 - Level of functioning
 - Special problems: AMA discharge, poor cooperation, and unstable condition
 - Details of diet, medication, activity, and education efforts
 - Followup visit plan

*Developed in part by the Colorado Foundation for Medical Care.

physician on the certification statement in the patient's medical record by virtue of his legal signature.

2. **Certification Statement.** The attending physician must attest to the accuracy and completeness of the principal and secondary diagnoses and the major procedures performed. This must be done before, at, or shortly after discharge, and before the bill is submitted. The certification statement must be signed and dated with the attending physician's legal signature.

The PRO is monitoring the hospital's compliance with both steps of the physician attestation procedure. We will ensure that hospitals have on file the annual signed acknowledgement of the penalty notice. We also will review to make sure that each medical record subject to our review has the signed and dated certification statement and that it includes the clearly identified principal diagnosis and principal procedure, correct certification text, and the physician's legal signature.

In terms of documentation, it is too soon to say what types of problems will arise as a result of the physician attestation procedure. However, the most common

documentation problem The PRO has faced to date is the failure of physicians to indicate that they are aware of and have addressed abnormal laboratory, x-ray, and/or EKG findings. While most physicians do manage these abnormal findings appropriately, many do not adequately record the actions they have taken in the medical record. The following are typical examples of cases that have triggered PRO questions due to a lack of chart documentation, thereby resulting in unnecessary paperwork for both the attending physician and The PRO.

- Review of a medical record revealed no indication of an EKG being performed on an elderly patient scheduled for surgery. The PRO questioned the attending physician. In responding to The PRO inquiry, the attending physician stated that an EKG had been performed during preadmission testing. The PRO obtained a copy of the EKG and subsequently approved the case. If the attending physician had indicated in the medical record that the test had been performed on a preadmission basis, The PRO would not have questioned the case.

- Review of a medical record indicated that a patient placed on Coumadin® was not given instructions regarding possible contraindications/complications. The PRO questioned the attending physician. The attending physician indicated that verbal instructions had been given to the patient and to the patient's family. The PRO then approved the case. If the attending physician had documented the instructions given regarding the medication, The PRO would not have questioned the case.

- Review of a medical record indicated that a patient had abnormal laboratory results on three different occasions during the same hospitalization. These abnormal laboratory findings were not explained in the attending physician's documentation. The PRO questioned the case. In responding, the attending physician stated that he was aware of the laboratory results but that the patient was anxious to go home. Therefore, the patient was discharged and was being monitored closely by the attending physician on an outpatient basis in an attempt to determine the reason for the abnormalities. If documentation was originally a part of the medical record, The PRO would not have questioned the case.

Another major problem encountered by The PRO when retrospective review is performed, is the absence of a discharge summary on the medical record. The discharge summary is the one element of the medical record that ties the whole case together and therefore is an area The PRO reviews closely. Although not all patients require a discharge summary, most patients do. It is important for attending physicians to dictate their summaries upon discharge or as soon as possible thereafter. The lack of a discharge summary on the medical record more often than not will trigger PRO questions.

As is evidenced in the examples provided, a great deal of time is spent both by The PRO and attending physicians in asking and responding to questions that never really need to be raised in the first place. Complete and legible documentation in the medical record can go a long way towards easing the workload of all involved.

THE UNCOMPENSATED CARE TRUST FUND AND THE MEDICARE WAIVER

MOLLY JOEL COYE, M.D., M.P.H., TRENTON*

The author presents a discussion on the Uncompensated Care Trust Fund, recently extended for two more years. In addition, the Medicare waiver and its effects on health care are mentioned.

Every national poll of the public or physicians in the past decade has reported a significant majority in support of guaranteed access to needed health care for all citizens. Despite this, the problem of medical indigency—of individuals who do not have health insurance, or are inadequately insured—has not yet been resolved in the United States. In a time of cost containment, pressure by private insurers to reduce hospital reimbursement, declining federal reimbursement, and rapid growth in the number of Americans without health insurance, hospitals and physicians in many states have been hard pressed to provide needed care. Many institutions have been forced to turn patients away or to absorb growing losses; some have resorted to patient “dumping,” which in turn has attracted national attention and condemnation.

This has not happened in New Jersey hospitals. Since 1980, all hospitals in the state have been fully reimbursed for the cost of charity and bad-debt care, as part of the Chapter 83 legislation that created the rate-setting system. The Uncompensated Care Trust Fund, established in 1987, has reimbursed hospitals for the uncompensated care they provide with monies derived from a uniform surcharge added to hospital rates for all hospitals and deposited in the Fund. Thanks to the Trust Fund, hospitals in our state providing a large amount of uncompensated care have

been able to shoulder this load, remain solvent, and continue to fulfill their crucial role as caregivers to the entire New Jersey community.

The Trust Fund was due to “sunset” at the end of 1988. This potential disaster for our hospitals—and for the uninsured—was averted by the last-minute passage of Senate Bill 2981 by the Legislature in January. The Trust Fund now is extended for two more years. At the signing ceremony, Governor Kean noted that for some New Jersey hospitals the Trust Fund “means the difference between maintaining services and closing their doors.” On behalf of the entire New Jersey health care community, I am relieved and grateful for this solution.

The Trust Fund will function much as it has in the past, although the surcharge is capped at 13 percent of total hospital revenue. The cap will provide adequate revenues to the Fund for 1989, but it probably will be necessary to request an increase for 1990. The legislation also continues the Trust Fund Advisory Committee, and charges it with recommending alternative methods of funding uncompensated care, initiatives to reduce it, and methods of expanding health insurance coverage.

*Dr. Coye is the New Jersey State Commissioner of Health. Correspondence may be addressed to Dr. Coye, New Jersey State Department of Health, CN 360, Trenton, NJ 08625-0360.

As in the past, the Trust Fund pays only for hospital-based care, not for private physician office visits or for the physician's component of a hospital stay (unless he is salaried by the hospital). For this reason among others, the Trust Fund to my mind is just one important step down the road to universal coverage which would reimburse every provider of care, including the private physician. Another step in this direction has been the innovative HealthStart program, started by the State Department of Health and Human Services just a year ago. HealthStart significantly increased physician reimbursement under Medicaid for prenatal, delivery, postpartum care. Over 100 New Jersey physicians now are enrolled in the program, and by April 1988 were being reimbursed nearly \$900 for these services, compared to \$236 before the advent of HealthStart. HealthStart also provides additional reimbursement for preventive pediatric visits.

It is a well-established, if not particularly surprising fact, that people with chronic health problems who have insurance avail themselves of medical care more frequently than those who do not. As a further step toward increasing the number of people with health insurance in the state, the new legislation also established a pilot insurance program to reduce uncompensated care. This program will be targeted at small businesses, because fully 70 percent of New Jersey's 843,000 uninsured are tied to the workplace, and primarily to enterprises with 20 or fewer employees. The program will "prime the pump" by offering premium subsidies to small businesses to encourage the purchase of insurance. The subsidies will be drawn from \$6 million in funds which were given to the Department of Health by the Legislature as seed money at the time of the establishment of the Uncompensated Care Trust Fund. The legislation also requires that employers in this state who do not provide health insurance coverage to their employees must inform them about the importance of having this coverage, and make a good-faith effort to assist any employee who wishes to purchase it.

Finally, the new legislation will require all New Jersey full-time college students to maintain basic health insurance for the length of their enrollment. Both public and private colleges and universities must offer this coverage for purchase on an individual or group basis. The State Board of Higher Education is charged with the implementation of this program. I am optimistic that through these and other initiatives we will be able to reduce significantly the number of New Jersey citizens who lack health insurance, thereby improving

the general quality of our health services and lessening the weight of uncompensated care on our hospital system.

Over the last five years, New Jersey has been one of the few states with a Medicare waiver; indeed, the Chapter 83 system was so successful in constraining costs during that time that Medicare, in effect, followed our regulations. As the federal government reduced its Medicare reimbursement level below what New Jersey pays, however, we opted to terminate the waiver. What will this mean for New Jersey health care?

Certainly, it will have no effect on the excellent quality of care our system provides. The chief advantage of operating under the waiver was its relative simplicity of procedure for both the state bureaucracy and hospitals, particularly in combination with Medicare's periodic interim payments (PIP). These payments provided hospitals with a front-ended, predictable flow of revenue which approximated Medicare payments for hospital bills. This greatly facilitated cash flow for our hospitals. The bad news is that PIP now is gone along with the waiver; the good news is that the federal Health Care Financing Administration (HCFA) recently has agreed to make "accelerated payments" to hospitals over the next several months to facilitate a general weaning from PIP. It is my hope that all New Jersey hospitals will be self-sufficient in this regard in nine months or less. As has been the case in the past, expedited physician attestation will aid the hospitals tremendously in preparing and mailing their bills, and in obtaining timely reimbursement. I know I can count on New Jersey's physicians to keep this in mind as they process the considerable paperwork which accompanies patient care under the federal system.

Finally, it is significant to note that the termination of New Jersey's waiver makes the continued operation of the Trust Fund even more vital. Almost half of the state's uncompensated care was hitherto paid by Medicare. Now the payers, working in concert with this rational and even-handed instrument, will be able to respond effectively to the new situation and absorb the increased costs to hospitals.

Through the Uncompensated Care Trust Fund, New Jersey has become a leader in the effort to provide nearly universal hospital coverage for its residents. Effected through a broad consensus of the state's health care community and its legislators, the Trust Fund will continue to help keep our hospitals solvent, to contain their costs, and, ultimately, to effect an equitable distribution of the burden of, and benefits from, the provision of medical care for our larger community.

DR. MURIEL M. GARDINER: PSYCHIATRIST AND PHILANTHROPIST

FRED B. ROGERS, M.D., TRENTON*

An American physician, Dr. Muriel Gardiner was concerned with humanitarian and environmental matters. Her teachings and writings in psychiatric and social realms reflected her zeal to improve human health and happiness.

Muriel M. Gardiner, M.D., a wealthy American woman physician who trained as a psychoanalyst in Vienna, Austria, spent over half of her long life in New Jersey. She was concerned with humanitarian and environmental matters, and her teaching and writings in psychiatric and social realms reflected personal zeal to improve human health and happiness. A well-documented record of philanthropy has been amplified since her death to effect a secure position for Muriel Gardiner in modern history. Her generosity made possible continued research in psychoanalysis. In the British textbook, *Psychological Medicine*, Dr. Desmond Curran wrote: "Whether the theories of the various psychoanalytic schools find general acceptance or not, whether their claims are justified or not, and whatever their limitations in practice, they have made contributions to a further understanding of the mind and its more subtle mechanisms."¹

Helen Muriel Morris was born in Chicago, Illinois, on November 23, 1901, the youngest child in a family of two boys and two girls. Her father, Edward Morris, was the eldest son of Nelson Morris, founder of Morris & Company, one of the largest meat-processing companies in Chicago. Her mother, nee Helen Swift, was a daughter of Gustavus Swift, founder of Swift & Company, another of the great Chicago meat-packing firms.

The family was wealthy and prominent; Muriel's uncle, Ira Morris, became United States Minister to Sweden, and her uncle, Harold Swift, was president of the Board of Trustees of the University of Chicago. After graduating from Chicago's Faulkner School in 1918, Muriel entered Wellesley College, where her mother had been in the class of 1892. Four years later, the daughter received a bachelor of arts degree, having majored in literature and history. At Wellesley, she read *The Freudian Wish* (1915), by Edwin B. Holt, psychology professor at Harvard and Princeton; this book had a lasting impact.²

Following graduation from college, Muriel spent a year in Italy as a student at the American School of Classical Studies in Rome, and witnessed the rise of Mussolini and his black-shirted fascists. The next two years, she spent at Oxford University, doing graduate work in English literature as a preparation for teaching. In 1926, Muriel Morris ventured to Vienna, seeking to be psychoanalyzed by Dr. Sigmund Freud; he referred her to an American pupil-analyst, Dr. Ruth Mack Brunswick, daughter of Judge Julian Mack of the Chicago Juvenile Court. Years later, with Dr. Brunswick, she coauthored a book about Freud's famous patient, the Wolf-Man, that would be a land-

*Correspondence may be addressed to Dr. Rogers, 333 West State Street, Apt. 6-K, Trenton, NJ 08618.



Muriel M. Gardiner, M.D.

mark in psychiatric literature.³ Muriel became acquainted with Dr. Freud and his family; daughter Anna Freud remained a good friend over the years.

After a period of residence in New York City, Muriel returned to Vienna where she married an Englishman, Julian Gardiner. Their daughter, Connie, was born in 1931, and her parents subsequently were divorced. In 1932, Muriel Gardiner enrolled in the University of Vienna Medical School, and six years later, received her medical degree. (Her sister, Ruth Bakwin, earned a medical degree from Cornell University earlier and practiced pediatrics in New York City). In November 1939, Dr. Gardiner returned with her daughter and second husband Joseph Buttinger to the United States, settling at the 200-acre Brookdale Farm in Pennington, where they resided for the next 45 years. The two-family farmhouse was shared with their lawyer-friend Wolfgang Schwabacher and his family. Mr. Schwabacher, prior to his death in 1951, also was attorney for the author-playwright Lillian Hellman, and told her about Dr. Gardiner's activities with Joseph Buttinger and others in the Austrian underground before and during the Nazi annexation of Austria by Hitler early in 1938. Miss Hellman's portrait of "Julia" in her best-selling book *Pentimento* (1973) was doubtless based upon these doings.^{4,5}

After locating in New Jersey, Dr. Gardiner served a year's rotating internship at Mercer Hospital in Trenton during 1942 to 1943, and worked with the Bureau of Venereal Disease Control of the New Jersey State Department of Health for 18 months thereafter. From 1946 to 1947, she was a resident in psychiatry at Marlboro State Hospital; after this, she worked as a psy-

Dr. Gardiner was a driving force in preserving Freud's London home and was instrumental in founding the Center for Advanced Psychoanalytic Studies of Princeton.

chiatrist at the New Jersey State Hospital in Trenton, and as director of four mental health clinics.

Completion of psychoanalytic training at the Institute of the Philadelphia Association for Psychoanalysis led to practicing analysis full time, then combining practice with teaching at the Institute, at various hospitals and social agencies, and at Rutgers University School of Social Work and Department of Education. Dr. Gardiner contributed numerous perceptive articles to the *Bulletin of the Philadelphia Association for Psychoanalysis* and was a member of its editorial board for ten years (1951-1961). Four of her articles are especially readable: "Squirrel's Dreams" (1952), "The Life Self and the Death Self" (1953), "A Snowfall Memory" (1963), and "A Contribution to the Psychology of Femininity" (1972). In the June 1972 *Bulletin*, guest editor Dr. Samuel A. Guttman, professor of psychiatry at Jefferson Medical College, paid tribute to Muriel Gardiner on her 70th birthday.⁶ During the previous year, she had contributed an introduction to Edith Kramer's signal book, *Art as Therapy with Children*.⁷

In 1976, Dr. Gardiner's book, *The Deadly Innocents: Portraits of Children Who Kill*, based on her work with children and adolescents, appeared with a preface by her English author-friend Sir Stephen Spender.⁸ This volume stemmed from 15 years of experience as a psychiatric consultant and member of child study teams, first in the public schools of Bucks County, Pennsylvania, and then for the New Jersey State Department of Education in Gloucester and Salem county schools. *The Deadly Innocents* is a grim account of ten youthful offenders, case studies of victims as well as victimizers, portrayed with sympathy and understanding. The doctor regarded her efforts in preventive psychiatry as "the best work I ever did in my life."⁹

Of numerous philanthropic activities, service with the Austrian underground and international relief organizations is chronicled in Dr. Gardiner's candid memoir, *Code Name "Mary"*; her longtime friend Anna Freud wrote the foreword to the 1981 book.¹⁰ A motion picture, "The Real Julia," issued in 1988 by Altana Films of New York City, also depicted Muriel Gardiner's courageous contributions. For work with refugees, she was awarded the Austrian Cross of Honor, First Class, in 1980 at a ceremony in the Austrian Consulate at New York City.¹¹

Dr. Gardiner was a driving force in the New Land Foundation, which preserved Freud's London home and archives; it opened in 1986 as a museum and cultural center. She also was instrumental in founding the Center for Advanced Psychoanalytic Studies of Princeton. Late in life, Dr. Gardiner gave the farm-

house in which she and her husband lived, and much of the surrounding sylvan acreage, to be the headquarters of the Stony Brook-Millstone Watershed Association for environmental conservation. They continued to reside in a cottage on the property until shortly before her death from lung cancer on February 6, 1985, at The Medical Center at Princeton.¹²

In honor of her friend, Margherita Condell, a teacher of French at Princeton's Stuart Country Day School of the Sacred Heart, Muriel Gardiner established a student scholarship. Among many tributes of appreciation and affection for Dr. Gardiner, that of Sister Margherita is most apt: "She was gracious and generous as well as gifted in her profession."

REFERENCES

1. Curran D, et al.: *Psychological Medicine: An Introduction to Psychiatry, Edition 9*. Edinburgh, Churchill Livingstone, 1980, p. 373.
2. Holt EB: *The Freudian Wish and its Place in Ethics*. New York, NY, Henry Holt and Company, 1915.
3. Gardiner M: *The Wolf-Man by the Wolf-Man*. New York,

NY, Basic Books, Inc., Publishers, 1971.

4. Hellman L: *Pentimento: A Book of Portraits*. Boston, MA, Little, Brown and Company, 1973, pp. 101-147.

5. Mansfield S: Muriel Gardiner, *Echoes of 'Julia'*. Washington D.C., *The Washington Post*, July 6, 1983, p. B-1.

6. Guttman SA: To M.M.G.—a tribute, *Bull Phila Assn Psychoanalysis* 22(2): 96-102, 1972.

7. Gardiner MM: Introduction, in Kramer E, *Art as Therapy with Children*. New York, NY, Schocken Books, 1971, pp. ix-xi.

8. Gardiner M: *The Deadly Innocents: Portraits of Children Who Kill*. New York, NY, Basic Books, Inc., Publishers, 1976.

9. Johnson BL: *Obituary of Dr. Muriel Gardiner*. Princeton, NJ, *Town Topics*, February 13, 1985, p. 30.

10. Gardiner M: *Code Name "Mary": Memoirs of an American Woman in the Austrian Underground*. New Haven, CT, Yale University Press, 1983.

11. Johnson BL: *Dr. Muriel Gardiner's Book, Code Name "Mary," Recalls Her Life as Heroine of the Austrian Underground in the 1930s*. Princeton, NJ, *Town Topics*, June 22, 1983, p. 1-B.

12. Berger J: Muriel Gardiner, Who Helped Hundreds Escape Nazis, Dies. New York, NY, *The New York Times*, February 7, 1985, p. D-22.

FLORIA and CALLORI

Attorneys at Law

★ Experienced in representing the
Medical Profession ★

COLLECTION—
SALE AND PURCHASE OF BUSINESS
GUARDIANSHIP AND
CONSERVATORSHIP PROCEEDINGS
PERSONAL INJURY—
REAL ESTATE—MATRIMONIAL

FLORIA and CALLORI

130 Pompton Avenue
Verona, New Jersey 07044
(201) 857-0400

MEDICAL OFFICE MANAGEMENT SOFTWARE \$750.00

Instant medical forms/monthly statements
Comprehensive. IBM XT, AT, clones
Purchase software only (FREE DEMO DISK)
or Complete system (hardware/software)
for less than \$2000.00

Leonard Waldman MD FACS 201-355-3700

700 North Broad Street
Elizabeth, NJ 07208

WHERE DO THEY GO WHEN YOU
TELL THEM TO LOSE WEIGHT?
TREAT THEM IN YOUR OFFICE



Nutri-Lene

State-Of-The-Art Supplemented Fasting Program

- | | | |
|-----------------------|---------------------|---------------------------|
| • Safe | • No Weighing Food | • Economical |
| • Medically Proven | • No Measuring Food | • Convenient |
| • Simple | • No Gimmicks | • Sold To Physicians Only |
| • Effective | • No Shipping Costs | • Physician Owned Company |
| • No Calorie Counting | | |

For information, samples, or a free tutorial, call: 201-836-2476
or 800-333-9399. Medical Weight Management, Inc., 740 Car-
roll Place, Teaneck, N.J. 07666

The complete journal for family practice physicians

- Reaches 79,000 family physicians monthly
- Presents the most commonly seen patient problems in family practice
- Written by physicians for physicians
- The most current clinical updates in:
Cardiology Pediatrics Psychiatry
Diabetes Ob/Gyn Gastroenterology
- Provides 20 hours of CME Category 1 Credit

PRACTICAL • CLINICAL • EDUCATIONAL • CURRENT

Family Practice Recertification Greenwich Office Park 3, Greenwich, CT 06831 / (203) 629-3550

FP R

Family Practice Recertification®

DECEMBER 1987 / VOL 9, NO 12

FAMILY PRACTICE SKILL

- Controlling Epistaxis

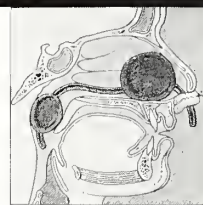
CLINICAL ARTICLES

- Drug Therapy for Manic Illness
Therapeutic Guidelines for Use of Nonsteroidal
■ Antinflammatory Drugs for Rheumatic Disorders:
Salicylates

KEEPING CURRENT

- | | |
|--|---|
| Does a Definite Diagnosis
Help Patients Get Better?
Screening for Liver Metastases
Significance of Elevated
Erythrocyte Sedimentation Rates
Glucose Tolerance and
Pregnancy Complications
Among Nondiabetic Women | Can Obese Type II Diabetic
Patients Use Fructose as a
Sweetener?
Comparison of Diagnostic
Tests for Evaluating
Dementia
Psychiatric Reactions Caused
by Lidocaine Toxicity |
|--|---|

CUMULATIVE INDEX



Epistaxis balloon catheter, page 20

LIMITED RESECTIONS FOR LUNG CANCER

LEWIS WETSTEIN, M.D., AND AMY BRENNER, R.N., FREEHOLD*

Patients with lung cancer frequently are inoperable because of poor pulmonary reserve. Some patients who cannot tolerate a pneumonectomy or lobectomy can tolerate a limited resection, i.e. wedge or segmental excision for cure. The results of our study reveal that limited resection for lung cancer appears to be an acceptable alternative to lobectomy for localized cancer, especially in poor-risk patients.

Pulmonary resection for malignant disease has evolved dramatically during the past century. In fact, lung resection was frowned upon in the last century because of significant complications and dismal results.¹ Subsequently, however, excellent results were obtained with pneumonectomy.² Until recently, anything short of pneumonectomy for lung cancer was condemned.³ It was not until 1950 that lobectomy was demonstrated to be the procedure of choice when the disease was limited to a lobe or lobar bronchus.⁴

Today, the issue of tissue salvage has become increasingly important in pulmonary surgery. Patients with lung cancer frequently are inoperable because of poor pulmonary reserve. Some patients who cannot tolerate pneumonectomy or lobectomy can tolerate a limited resection. The surgeon, therefore, must resolve the dilemma of the adequacy of the resection versus the excessive loss of uninvolved parenchyma with the possibility of a respiratory deficit. Some surgeons advocate elective segmentectomy or wedge resection for small peripheral lung carcinomas.^{5,8} There still is concern, however, that localized resection may fail to remove all malignant tissue and lymphatic spread. This places the patient at increased risk of local recurrence and decreases the chance of long-term survival compared to standard resections, i.e. lobectomy and pneu-

monectomy. The purpose of the present study was to evaluate the results of limited resection for pulmonary malignancy in a select group of patients.

PHASE I: MATERIALS AND METHODS

Twenty-two consecutive patients with peripheral bronchogenic carcinoma from July 1, 1984, through January 1, 1985, from the Medical College of Virginia and Hunter Holmes McGuire VA Medical Center entered the study (Table 1). The diagnosis of stage 1 peripheral bronchogenic carcinoma (less than or equal to 3 cm) was made jointly by the pulmonologist, radiologist, and thoracic surgeon based on history, physical examination, bronchoscopy, and mediastinoscopy. Pulmonary functions were assessed preoperatively with spirometry, exercise oxygen consumption, and rest and exercise arterial blood gases.

All patients underwent rigid bronchoscopy under general anesthesia prior to resection. Nineteen patients subsequently underwent a posterolateral thoracotomy and the remaining 3 patients, because of

*Supported in part by Grant #1 R23 HL34515-01A1 from the National Heart, Lung, and Blood Institute, Bethesda, MD, and from the Veterans Administration Merit Review Grant Award. Dr. Wetstein is the recipient of the NIH New Investigator Award. Correspondence may be addressed to Dr. Wetstein, Central Jersey Surgical Associates, 4 Bridge Plaza Drive, Manalapan, NJ 07726.

TABLE 1
Characteristics of Phase I Patients

Patient	Age	Pathology	Resection
1	64	Squamous cell CA	LUL
2	58	Adeno CA	RUL
3	61	Adeno CA	RLL
4	66	Squamous cell CA	RUL
5	55	Adeno CA	RUL
6	68	Squamous cell CA	RUL
7	64	Small cell CA	LUL
8	76	Squamous cell CA	LUL
9	73	Adeno cell CA	LUL
10	66	Squamous cell CA	RLL
11	66	Adeno CA	RUL
12	60	Adeno CA	RUL
13	67	Adeno CA	RUL
14	74	Squamous cell CA	LUL
15	56	Adeno CA	RUL
16	64	Adeno CA	RML
17	71	Squamous cell CA	LLL
18	63	Squamous cell CA	RML
19	62	Squamous cell CA	RLL
20	63	Adeno cell CA	LLL
21	60	Squamous cell CA	LLL
22	69	Squamous cell CA	RUL

RUL: Right upper lobe LUL: Left upper lobe
 RLL: Right lower lobe LLL: Left lower lobe
 RML: Right middle lobe

bilateral lesions, underwent median sternotomy. A limited resection removing the entire lesion was performed in all patients. Frozen section histopathological evaluation uniformly revealed that the margins of the lesions were free of tumor. Subsequently, all patients underwent a completion lobectomy.

Pulmonary functions for inclusion in various groups were defined. *Pneumonectomy*. A 1/sec forced expiratory volume (FEV₁) of greater than 1.6 l/sec or suitable split function analyses to assure the patient of a FEV₁ of 0.8 l/sec postresection; a maximum breathing capacity (MBC) greater than 50 percent of predicted; and a forced expiratory flow FEF_{25-75%} of greater than 1.4 l/sec (Table 2). *Lobectomy*. A FEV₁ greater than 1.2 l/sec; a MBC greater than 40 percent predicted; and a FEF_{25-75%} greater than 0.8 l/sec (Table 2). *Wedge Resection/Segmentectomy*. A FEV₁ greater than 0.9 l/sec; MBC greater than 35 percent predicted; and FEF_{25-75%} greater than 0.6 l/sec (Table 2).

Clinical and radiological followup included: history, physical examination, complete blood count with differential, chemistry profiles, and posteroanterior and lateral chest roentgenograms performed at two weeks after discharge from the hospital (one month, three months, six months, and then semi-annually). Morbidity was divided into minor and major complications (Table 3). Minor complications included atelectasis, endotracheal intubation greater than 48 hours, prolonged air leaks greater than 72 hours, arrhythmias, pneumonia, and wound infections. Major morbidity consisted of hemorrhage, bronchopleural fistula, em-

TABLE 2
Static Pulmonary Function

Pneumonectomy

- FEV₁ > 1.6 liters/sec
- MBC > 50%
- FEF_{25-75%} > 1.5 liters/sec

Lobectomy

- FEV₁ > 1.2 liters/sec
- MBC > 40%
- FEF_{25-75%} > 0.8 liters/sec

Wedge/Segmental Resection

- FEV₁ > 0.9 liters/sec
- MBC > 35%
- FEF_{25-75%} > 0.6 liters/sec

TABLE 3
Minor Complications

Atelectasis
 Prolonged intubation (48 hrs)
 Prolonged air leak (> 72 hrs)
 Arrhythmias
 Pneumonia
 Wound infection

Major Complications

Hemorrhage
 Bronchopleural fistulas
 Empyema
 Respiratory failure
 Death

pyema, respiratory failure, and death.

Followup information was obtained by personal examination at the clinic, direct correspondence, and communication with referring physicians. Information was obtained from hospital records, autopsy findings, and relatives for patients who died. Mean follow-up time was approximately 32 months (range 30 to 36 months) for patients alive in 1987. Pulmonary function studies were not evaluated postoperatively.

RESULTS OF PHASE I

Twenty patients were male, and 2 patients were female. The mean age was 63 years (range 52 to 76 years). There were 11 squamous cell carcinomas, 10 adenocarcinomas, and 1 undifferentiated carcinoma (small cell). All tumors were preoperative stage I (Table 1).

After the initial limited resection, all patients underwent completion lobectomy. Four (18 percent) patients had spread of their parenchymal disease to local lymph nodes; disease in two patients spread to the mediastinum. The latter two patients were treated in the nodal excision and postoperative mediastinal radiotherapy. No patient had evidence of tumor after extensive histopathological permanent sectioning of the lobectomy tissue. The 30-day operative mortality was zero and there were no major complications. Minor

complications included prolonged intubation in two patients (9 percent); prolonged air leak in two patients (9 percent); atelectasis in one patient (5 percent); and wound infections in one patient (5 percent). Overall morbidity was 18 percent (four patients) (Table 4).

PHASE II: MATERIALS AND METHODS

Based on preliminary results from the phase I study, from January 1, 1985, through January 1, 1987, nine consecutive patients with borderline pulmonary resection deemed unsuitable for lobectomy by pulmonary function testing were evaluated for surgery (Table 5).⁹ Preoperative assessment was similar to the phase I patients.

After rigid bronchoscopic evaluation under general anesthesia, a posterolateral thoracotomy was performed. A limited resection was performed removing the entire lesion. No further surgery was performed after frozen section histopathological evaluation confirmed that the margins of the lesions were tumor free.

Clinical and radiological followup was the same as in the phase I patients. Phase II patients were similar for morbidity. The difference between phase I and phase II patients, including operative morbidity, mortality, and survival, was assessed employing a T-test for paired and nonpaired data where appropriate. Mean

followup time has been approximately 24 months (range 4 to 28 months) for patients alive in 1987.

RESULTS OF PHASE II

All the lesions were bronchoscopic carcinoma stage I. Eight patients were male and one patient was female. Mean age was 65.3 years (range 52 to 81 years). There were four squamous carcinomas and five adenocarcinomas.

A segmentectomy was performed in four patients, and a wedge resection in five patients (Table 4). One (11 percent) of the patient's tumor had spread to mediastinal lymph nodes.

Operative mortality was zero; all patients left the hospital. Complications included prolonged intubation in one patient (11 percent); and prolonged air leak in one patient (11 percent). Overall morbidity was 11 percent (one patient) (Table 4).

There was no difference in operative morbidity or mortality between the patients in either group (P=NS). Two patients died in the lobectomy group, while all patients in the segmentectomy (four of four) and wedge-resection groups (five of five) remain alive from 4 to 28 months postoperatively (Table 6). Survival is similar between the groups (P=NS).

DISCUSSION

Bronchogenic carcinoma is the leading cause of death from malignancy in the American adult population.¹⁰ Five-year survival is improving with surgical resection. Unfortunately, many of these patients have compromised cardiopulmonary function which may prevent a lobectomy or pneumonectomy being performed.⁵ Furthermore, these patients may develop subsequent pulmonary primaries after adequate resection.⁷ Therapy of these secondary and tertiary primaries may be limited by previous resections. Limiting pulmonary resection to segmental and/or wedge resections, therefore, will allow increased resection capabilities in these situations. Our results demonstrate that short-term survival following limited resection is similar to more extensive resections, and the patient

TABLE 4
Complications
Lobectomy

Prolonged intubation	2	(9%)
Prolonged air leak	2	(9%)
Atelectasis	1	(5%)
Wound infection	1	(5%)
Overall morbidity	18%	(4)

Limited Resections

Prolonged intubation	1	(11%)
Prolonged air leak	1	(11%)
Overall morbidity	11%	(11)

TABLE 5
Characteristics of Phase II Patients

Patient	Age	Pathology	Resection
1	52	Adeno CA	Wedge resection RUL
2	64	Squamous cell CA	Segmentectomy sup. segment RUL
3	67	Adeno CA	Lingulectomy
4	57	Squamous cell CA	Wedge resection RUL
5	69	Adeno CA	Segmentectomy sup. segment LLL
6	81	Adeno CA	Wedge resection RUL
7	65	Adeno CA	Segmentectomy sup. segment LLL
8	72	Squamous cell CA	Wedge resection LLL
9	59	Squamous cell CA	Wedge resection RUL

RUL: Right upper lobe
RLL: Right lower lobe
LLL: Left lower lobe
LUL: Left upper lobe

TABLE 6

Survival

Procedure	Patients	Surviving Patients
Segmentectomy	4	4
Wedge resection	5	5
Lobectomy	22	20

is spared the greater physiologic insult associated with a more radical procedure.

The argument of uniformly performing a lobectomy consists of the concern about cutting across lymphatic and vascular channels when performing a limited resection. It is not uncommon, however, to cut across vascular and lymphatic channels during a lobectomy when an incomplete fissure is present. Thusly, separation of fused lobes in performing a lobectomy is analogous to the separation through the plane between segments in performing a segmentectomy or even a wedge resection in a peripheral tumor, which tends to refute that argument.

CONCLUSIONS

Performance of a segmentectomy or wedge resection may decrease operative morbidity and mortality in poor-risk patients.

Local recurrences have not been noted in any of these patients.

Wedge and/or segmental resections appear to be as effective as lobectomy for localized disease (stage I) up to 30 months, especially in poor-risk patients.

REFERENCES

1. Reclus K: French Surgical Congress (1985), in Padgett, *Surgery of the Chest*, 1896.
2. Graham EA, Singer JJ: Lung removal for carcinoma of the bronchus. *JAMA* 101:1371-1374, 1933.
3. Ochsner A, DeBakey NE: Primary pulmonary malignancy: Treatment by total pneumonectomy analysis of collected cases and presentation of seven personal cases. *Surg Gynecol Obstet* 68:435-451, 1939.
4. Churchill ED, Sweet RH, Soutter L, Scannel JG: The surgical management of carcinoma of the lung. A study of the cases treated at the Massachusetts General Hospital from 1939 to 1950. *J Thorac Surg* 20:349-365, 1950.
5. Jensik RJ, Faber LP, Kittle CF: Segmental resection for bronchogenic carcinoma. *Ann Thorac Surg* 28:475-483, 1979.
6. Errett LE, Wilson J, Chiu RC-J, Munro DD: Wedge resection as an alternative procedure for peripheral bronchogenic carcinoma in poor-risk patients. *J Thorac Cardiovasc Surg* 90:656-661, 1985.
7. Jensik RJ: Conservative resection for lung cancer, in, *International Trends in General Thoracic Surgery*, Volume 1, 1985. W.B. Saunders, Philadelphia, PA, pp 100-103.
8. Frist WH, Mathisen DJ, Hilgenberg AD, Crillic HC: Bronchial sleeve resection with and without pulmonary resection. *J Thorac Cardiovasc Surg* 93:350-357, 1987.
9. Bechard D, Wetstein L: Assessment of exercise oxygen consumption as preoperative criterion for lung resection. *Ann Thorac Surg* 44:344, 1987.
10. Silverberg E, Lubera J: Cancer statistics, 1988. *CA* 37:2-20, 1988.

SPECIAL ARTICLE: YOUR PRESCRIPTION— AN INSTRUMENT OF YOUR LICENSE

FRANK J. MALTA, M.D., TOMS RIVER*

A prescription is an instrument of your license. It carries certain responsibilities to insure that medication prescribed is appropriately written with the necessary information. Prescribing of CDS over an extended period without valid medical reasons is to be avoided.

Recall, if you would, for some not too long ago, and for others long ago, but seemingly, only yesterday, the day you were introduced to materia medica in your second year of medical school. That was the day you were introduced to prescription writing. It was a day to remember. You began to feel, for the first time after entering medical school, like a physician. Remember the great care and interest you took to be sure that a correct and proper prescription was written, and how you could not wait for the day you would be able to write a genuine prescription for a patient who was examined by you—to write a prescription that would help the patient to feel better and, perhaps, to be cured.

Upon completion of medical school, postgraduate training, and licensure, prescription writing became very routine. As greater demands were placed upon your time, you had to perform more efficiently and with greater speed in order to tend to more patients. The prescription contents began to be condensed.

Age no longer became important (yet one was taught the importance of age, especially in pediatric or elderly patients), and the address was not necessary, as the pharmacist would fill this in before dispensing to the patient. One did not realize that the name, age, address, telephone number, and practice designation are important to the pharmacist who must determine that a legitimate prescription was written. It would help the

pharmacist to insure that if there were two or more John Smiths, he did not confuse your prescription if refills were requested. It would help the pharmacist also in suspecting or asking questions if a fraudulent prescription had been written when pertinent data on the prescription was improperly completed or omitted. The young age on the prescription might alert him as to whether a prescription written for a controlled dangerous substance (CDS) would be taken by a substance abuser who might be acting strangely or in a nervous way. Federal and state regulations require that CDS prescriptions have a physician DEA number. It helps the pharmacist to be sure a physician is registered and is able to prescribe such drugs, as well as checking whether a fraudulent prescription was made by a drug abuser. One should avoid having the DEA number embossed on the prescription in order to make it difficult for a drug abuser to fraudulently write a prescription on a stolen prescription blank.

Writing legibly avoids serious mistakes in dosage, directions, and medication. This is protection for you, your patient, and the pharmacist. It also avoids the need for the pharmacist to call the physician for clarification regarding a prescription. It should be routine, not only when prescribing a schedule II drug, e.g. De-

*Dr. Malta is president of the State Board of Medical Examiners. Correspondence may be addressed to Dr. Malta, 7 Hospital Drive, Toms River, NJ 08753.

merol[®], morphine, Percodan[®], which requires the quantity be written in longhand, as well as other categories of CDS, in order to prevent an abuser from changing a three into an eight. It is your responsibility to protect your prescription, as much as possible, from abusers whom you may not suspect.

Your signature is the endorsement that makes the prescription negotiable. Make every effort to avoid forgery. Your printed name should appear somewhere on the prescription in order for the pharmacy to identify properly the prescriber.

A prescription and prescription pad may be compared with your personal checks. These may be stolen and used illegally. One certainly would not want to have a checking account emptied by someone forging one's signature. Nor should you want someone to obtain your prescription pad in order to get drugs for illicit purposes. Just as you may try not to leave your checkbook in an easily accessible place, you must safeguard your prescriptions in your office or pocket. One can obtain prescription pads in serial numbers and with safeguard composition that would make it easy for a pharmacist to detect alterations. One also may make a code mark, known only by you, that would help you identify whether or not the prescription was forged.

As far as refills are concerned, sufficient medication should be prescribed, or allowed to be refilled, depending on the nature of the condition being treated. There should be frequent followup examinations to help ensure that the medication needs to be continued. Another safeguard in refill authorization would be

writing the number in longhand to minimize any possible alteration.

An undated or predated prescription is not an acceptable practice. The prescription should contain the date that the prescription was written in order to prevent a patient from filling a prescription earlier than intended.

Prescribing of CDS carries a responsibility to insure that the medication prescribed was for valid medical reason with the proper documentation in the medical records, the pertinent history (any past records), and physical findings, as well as consultation, laboratory or x-ray findings, to help support the justification for the prescribing, especially over an extended period of time. Efforts should be made to use CDS with the least potential for addiction, as well as modification of treatment regimens to include medication changes to offset addiction potentials, as well as referral for chronic pain evaluations or psychiatric evaluation, if need be.

Should you discover that your prescription pad has been stolen or mysteriously disappeared, you should contact your local police, pharmacist, drug enforcement bureau, and medical board immediately. You should then re-evaluate the adequacy of your prescription security.

You may not have had to be concerned about these details when you first wrote your prescription in *materia medica*. The times and practice of medicine, in a mobile population, as well as the problems that society is facing in dealing with drug abuse, make it imperative that your prescription is an instrument of your license and that it does not put you or your patient in jeopardy.

SPECIAL ARTICLE: OF FEELINGS AND MANNERS

EDITH T. SHAPIRO, M.D., ENGLEWOOD*

We are being offered complex explanations for the deterioration of relations between patients and physicians. Physicians hurt patients by bad manners. As manners improve, patients' anger will subside, and physicians will regain their reputations.

Eighty-six-year-old Mrs. Anna Schmidt says this hurts and that hurts, and her daughter is sick, and her social security check has not come. But the thing that hurts the most is that her doctor said, "Anna, you have anemia and something wrong with your thyroid, and here are some pills. Goodbye." He was so quick, so curt, and so brusque. She took the pills and she's been taking them, but she's afraid to call the physician to ask how long to take the pills. She does not know if the pills will mix with her glaucoma drugs or her heart and blood pressure pills, or if she remembered to tell him about those pills. He did not tell her to check back or call back. More or less, he told her to get lost. And he'd kept her waiting to begin with, while he joked with his nurse, and he was laughing when she left. He didn't even say, "Goodbye, Anna."

Fifty-four-year-old Sheila Knight, vice-president of a Fortune 500 company, had a hysterectomy for a huge fibroadenoma ten years ago. Currently, she is struggling courageously and successfully to cope with after-effects of curative and grossly disfiguring surgery for a rare, exotic, fiercely malignant neoplasm unrelated to the uterine lesion. A recent magnetic resonance imaging (MRI) scan, part of a routine survey for recurrence of the neoplasm, revealed a suspicious enlargement of an ovary. Ms. Knight telephones her gynecologist; the physician sends a message through her sec-

retary that she's too busy to talk, but will set up tests and see the patient in two weeks. Mrs. Knight waits the two weeks, finally gets to see her doctor, who is impatient and brusque because tests ordered have not arrived.

"I can't do anything without them," the physician says to the patient, implying, the patient feels that, "You are wasting my time. You are inefficient." Ms. Knight leaves after less than five minutes saying, "She messed up and didn't apologize. She acted almost as if she didn't know who I was, as if she had no idea of what I've been through. As if I didn't understand the implications of the MRI." When the bill for \$75 arrived punctually she did not pay it. "I will not see her again, either," Ms. Knight answered.

Mrs. Claudia Fields has battled spina bifida all her life. Stoic and uncomplaining, she has undergone endless surgical procedures. She married, had children, and worked for most of her life in spite of all this. During the last several years, she has been suffering from episodes of paroxysmal pain. Several consultants have said that Mrs. Fields's pain is authentic and that she may have pain medication during the attacks. Mrs. Fields's own doctor is sounding bored and annoyed

*Dr. Shapiro is clinical associate professor of psychiatry, UMDNJ-New Jersey Medical School. Correspondence may be addressed to Dr. Shapiro, 211 Dawson Place, Englewood, NJ 07631.

with her and increasingly disapproving. She thinks he suspects her of abusing opiates. She cannot convince her physician otherwise. For that matter, she can't get to talk to him too often because he never seems to have any time. Also, he fails to return telephone calls.

Mr. Bob Jones recently had a coronary infarction. In his presence, his wife asks the cardiologist, "How is he?" "I'm a darn sight better than he," is the jovial answer. Outside of the sick room, the physician offers more comfort. "With your husband, I'm sitting on a powder keg."

On a Sunday evening, young Johnny falls off his bicycle and breaks his leg. His family waits for two hours in the local emergency room until a doctor finally arrives, disheveled and sweaty, with his hair all over his face, and his shirt open to his navel. The radiologist who comes to look at the films, never removes the cigarette dangling from the corner of his mouth. Johnny's family calls an ambulance and has Johnny moved to another hospital. "These can't be real doctors," says the mother.

Mrs. Schmidt would long have been dead if it were not for the skill of her physician. Ms. Knight lives because the resources of contemporary medicine were mobilized on her behalf by an alert internist challenged by a formidably confusing clinical picture. Mrs. Fields is a medical miracle who has been written up in textbooks. Mrs. Jones freely admits that the same physician who joked callously about her husband, saved his life with a vigorous experimental treatment which he began "on a hunch" in an equivocal diagnostic situation.

These people owe their lives to their doctors, yet each has withdrawn from the care of the particular physician. Mrs. Knight says her experiences with doctors, capped by her encounter with the gynecologist, have convinced her that doctors are the "scum of the earth."

It is easy to be impatient with a patient as circumstantial as Mrs. Schmidt. Ms. Knight's gynecologist perhaps was flustered by the medical dilemma and the failure of the test results to arrive on time. Mrs. Fields's internist was at the end of his resources for helping her. As sometimes happens, the physicians revealed their true feelings, and gave the appearance of blaming the patients for the patient's misfortunes, and for the physicians' limitations and frustrations. Mr. Jones's cardiologist possibly believes that humor alleviates illness. Humor may indeed help some people cope with illness, but that usually is true only if it is the patient's own humor. A physician must dispense his humor very gingerly, lest it seem like callousness. Johnny's two emergency room doctors simply are boors.

All these situations have something in common. Most of them can be explained, but not explained away. Each is characterized by failure of what used to be an automatic braking mechanism: good manners. The patients suffer from hurt feelings caused by their physicians' bad manners.

Websters Dictionary defines manners as: 1. good customs or mode of life; 2. habitual conduct or moral character; or 3. social conduct or rules of conduct as shown in prevalent customs.

After World War II, the purging by our society of Victorian rigidities and of hypocrisies began and continued until seemingly all restraints went by the board,

including the requirement of good manners. If I were to recommend one book to read this year, it would be Judith Martin's treatise on manners, which begins: "Assertiveness. Looking out for number one, and other systems for the dissemination of rudeness are abhorrent to Miss Manners. That people should spend hours studying vile little books and then disciplining themselves so as best to add to the general unpleasantness in the world is shocking."²

In the previous generation, physicians were expected to have good manners. My 1961 medical school class might be the last class to have been bawled out by a professor for bad manners.

The scene is as vivid today as it was 28 years ago: we are seated in large un-air-conditioned auditorium, where cases are to be presented. We are invaded by a casual mood. I am chatting and joking with a classmate. I have kicked off my highheeled shoes and am waving my stockinged feet in the air. Several men have taken off their jackets, loosened their ties, and opened the top buttons of their shirts. Most of us are smoking. The atmosphere is picnic.

Dr. E, professor of medicine, walks in. He is white-faced with anger. When he judges that he has our attention, he says stonily, "Doctors, in a few moments there will be patients present." I do not remember his saying more. I have stopped listening to my friend's chatter and I am groping with my feet for my shoes. All around me my classmates sit up very straight. Cigarettes are put out. Shirts are buttoned, ties are tightened, and jackets go on. Professor E stands in front of us, looking on, waiting in the silence which has fallen. He looks at his watch and says, "Dr. Smith, you're presenting the first case, I believe." Smith leaps to his feet like a West Point cadet.

I became a teacher of medical students a few years later and times had changed. Decorum was not even implicit in the medical curriculum. In the interest of being liberal and contemporary, we tolerated, and continued to tolerate, slovenliness and rudeness in some students.

Absolute freedom from all constraints might work in an ideal society made up of absolute equals. In the real world, the gods have not distributed assets or liabilities equally. Inevitably, without consensual reminders of the need for limits, the strong impose on the weak, particularly in moments of stress.

In a physician's office, the patient always is at a disadvantage. The physician must wield power with dedication, and with utmost delicacy.

In the group of patients described, Mrs. Schmidt and Mrs. Fields are poor and powerless. Ms. Knight and Mr. Jones are wealthy and powerful, but when they become ill, they are nearly as helpless as the other two patients before the magic of medical knowledge embodied in their doctors. Ms. Knight admitted her own amazement: "My gynecologist was rude and arrogant, but I still waited for her for two weeks. Even after the way she treated me at the appointment, it took a lot of courage for me to walk out. I was afraid that she and only she knew something, something critical, something essential to my care. I knew that this was nonsense, but the feeling was very strong."

Medicine by no means is the only profession that has forgotten its manners. When our patients encounter

us, they are thrust into our rude company when they are at their most vulnerable and our bad manners are particularly painful and frightening. The patients suffer and they retaliate by maligning the profession.

Have you noticed how we have been belaguered and attacked from every direction? We are told that we do more harm than good. We overdiagnose, overtest, over-treat, and overcharge. People suggest our mental health and physical health are worse than our patients', and that we drug, drink, and commit suicide more than any other social group. Others believe our personal lives are a shambles; we divorce our spouses and neglect our children. Some suggest our ethics and morals are reprehensible since we lie, cheat, steal, and sleep with our patients.

People used to want to marry physicians. People used to brag about having physicians for friends. When a physician would walk into a gathering, a hush would fall as if the bishop had walked in. Now, what people want to do more than anything is to sue physicians. It seems to me as we've become smarter and better educated, more skilled at what we do, our reputation and our popularity have plummeted.

Science, not grace, was to be the salvation of mankind, according to new ideas which came with the scientific era about 200 years ago. The problem is that, simultaneously with increased skills and technical advances, we, with the rest of society, have forgotten the importance of dealing decently with people.

In medicine, we are being offered profound explanations for the change in relations between patients and physicians by ethicists, by moralists, by sociologists, and by psychoanalysts. We probably do need to be reminded periodically that medicine always has concerned itself, and should concern itself, with humanism as well as with the scientific method.

I'm not sure I really believe that physicians have forgotten the Hippocratic oath, nor that patients' expectations from physicians really have changed. I believe that the explanation may be a good deal simpler. I predict that as physicians curtail what Henry James called our "Amercian spontaneity," as we collectively improve our manners, our patients' anger will subside considerably, and our justly deserved reputation will be regained.

I am all for the liberation of the human spirit, such as it is, including the spirit imprisoned in physicians' bodies. Even if often only a very trivial spirit is liberated, more of it undoubtedly is better than less. But this emancipation refers to the emancipation of

the mind only. It is acceptable now to imagine the king's death, but it's still not acceptable to kill him. Emancipation stops at the gateway to the rights and feelings of others, particularly those who are weak and vulnerable.

Borrowing the words, if not his intended meaning, from Cowper:

Manner is all in all, whate'er is writ,

The substitute for genius, sense, and wit.³

At the very least, let us have manners.

Some time ago, a dental problem led me to a consultant who fixed what was wrong, but failed in a more significant way. At the end of the ordeal, I reached for the customary cup to rinse and restore my mouth. It was not there. The assistant kindly explained that the specialist had done away with the rinse cycle because it was just a patient habit, not really necessary for good dental care.

My own dentist, when asked about this, explained, "The dental equipment salesman told me that I should do away with the rinse because it is only an amenity. Patients are used to it, but they don't need it. It wastes office time. It costs money. The cup, according to the salesman, amounts to flushing a solid gold cadillac down the drain every year." She added, "I decided against taking the salesman's advice and doing away with the rinse. It occurred to me I would lose a whole lot more if I let patients walk out of my office with a bad taste in their mouths."

SUMMARY

Patients and physicians may be at odds these days because of physicians' bad manners, which lead to patients' hurt feelings.

I use cases to demonstrate that sick people, no matter how intelligent or powerful, feel helpless and awed, and are extremely sensitive to lapses in physicians' manners.

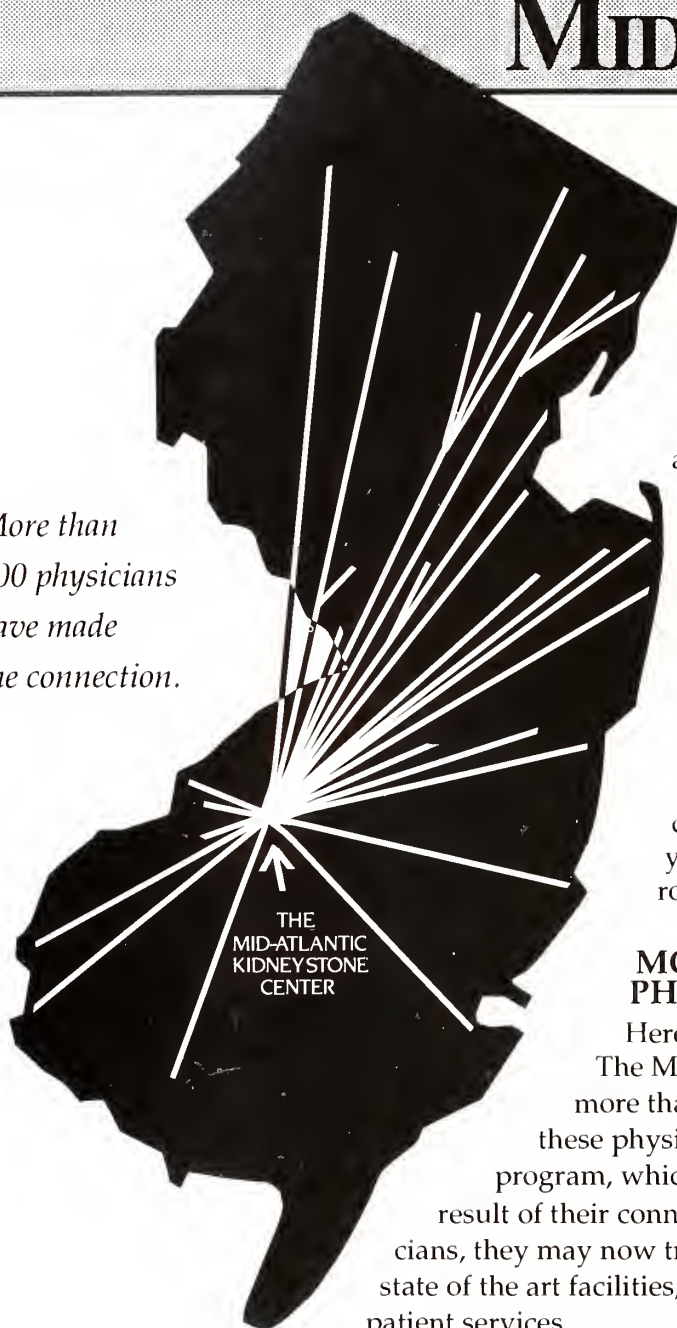
Good manners can help by being an automatic brake. Good manners are society's safeguard against the incoherent jumble of human feelings to which we are all subject. Translating such feelings into something more presentable, is what manners are about.

REFERENCES

1. *Websters 3rd International Dictionary*. Springfield, MA, Merriam Company 1971.
2. Martin J: *Miss Manners Guide to Excruciatingly Correct Behavior*. New York, NY, Warner Books, 1983.
3. Cowper W: *Table Talk*, 540. New York, NY, Everyman's Library, 1931.

EXPERIENCE & MID-ATLANTIC

*More than
100 physicians
have made
the connection.*



For physicians throughout New Jersey and from as far away as eastern Pennsylvania, metropolitan New York and Delaware, *Mid-Atlantic* is synonymous with *experience*.

Consider the following: we recently treated our 4,000th patient, a milestone for lithotripter units in the eastern region. Reading between the numbers, we see an unparalleled depth of experience that enables us to deliver the clinical excellence and full-service support you demand.

Additionally, we recently celebrated our third year of operation. Through this experience we have developed a unique sensitivity to your patients, your concerns and the role that we play as a service to both.

MORE THAN 100 STAFF PHYSICIANS AND GROWING

Here's another fact we're proud of: The Mid-Atlantic Kidney Stone Center has more than 100 physicians on staff. Many of these physicians learned lithotripsy through our program, which is now AUA and ALS certified. As a result of their connection to Mid-Atlantic as staff physicians, they may now treat their patients here, enjoying our state of the art facilities, full support staff and comprehensive patient services.

MAKE THE CONNECTION TODAY

Mid-Atlantic's experience is yours for the asking. To find out more about Mid-Atlantic's services and our physician training program, call us at 1-800-53-LITHO or (609) 983-7337.



**THE MID-ATLANTIC
KIDNEY STONE CENTER**

A LITHOTRIPTER SERVICE
One Brick Road, Suite 103
Marlton, NJ 08053

Managed by
MEDIQ Healthcare Resources, Inc.

CASE REPORT: SUCCESS OF CEFTIZOXIME IN *E. COLI* VENTRICULITIS

PIERRE N. COANT, M.D., SIDNEY J. SUSSMAN, M.D., ELIZABETH FONG-DELEON, M.D., CAMDEN*

A newborn infant developed ventriculitis caused by Klebsiella pneumoniae and Escherichia coli. Gentamycin eradicated the Klebsiella pneumoniae but had no effect on the E. coli, which was eliminated only through the use of ceftizoxime given intravenously.

Ventriculitis caused by gram-negative organisms in the neonatal period results in high morbidity and mortality.¹ Although the use of intraventricular vancomycin is well accepted in the treatment of gram-positive ventriculitis,^{2,3} the treatment of ventriculitis caused by gram-negative organisms is controversial. The use of intraventricular gentamycin has been discussed.^{4,6} Our patient had ventriculitis caused by *Klebsiella pneumoniae* and *E. coli*; he first was treated with gentamycin followed by ceftizoxime.

CASE REPORT

A 1644-gm male was born at 31 weeks' gestation. He developed respiratory distress syndrome and required mechanical ventilation. On day 2 of life, an ultrasound of the head showed a parietal lobe hemorrhage. Subsequent computerized tomography (CT) showed the formation of a porencephalic cyst with progressive hydrocephalus.

On day 32 of life, a ventriculoperitoneal (VP) shunt was inserted. Six days later, the infant developed bradycardia and was evaluated for sepsis. Cerebrospinal fluid (CSF) disclosed 274 neutrophils/mm³; 65 lymphocytes/mm³; 388,000 red blood cells/mm³; glucose, 24 mg/dl; protein, 199 mg/dl; and *Staphylococcus epidermidis* in culture. Vancomycin was given in a dose of 45 mg/kg/day, three times a day, in-

travenously for 15 days. Cerebrospinal fluid from the VP shunt was sterile after 5 days of treatment.

On day 53 of life, the infant became irritable, and CSF from the ventricular shunt showed 1,534 neutrophils/mm³; 4 lymphocytes/mm³; 1,052 red blood cells/mm³; glucose, 5 mg/dl; protein, 273 mg/dl; and *Klebsiella pneumoniae* and *E. coli* in cultures sensitive to gentamycin. Blood cultures, at that time and throughout the hospital course, were sterile. The infant was given gentamycin in a dose of 7.5 mg/kg/day three times a day, intravenously, but the organisms persisted. Subsequently, gentamycin, in a dose of 2.5 mg/day was instilled into the ventricles. Peak and trough levels in the CSF averaged 37 mg/dl and 4.9 mg/dl, respectively, all above the minimal inhibitory concentration.

By day 59 of life, intravenous and intraventricular gentamycin eradicated *Klebsiella pneumoniae*, but the *E. coli* remained. The ventricular shunt was removed, and ventricular taps were used to instill gentamycin. On day 10 of treatment, the *E. coli* changed into three strains as determined by biotyping, and two

*From the Department of Pediatrics, Cooper Hospital, where Dr. Coant is a pediatric resident, Dr. Sussman is chief of the Department, and Dr. Fong-deLeon is a neonatologist. Correspondence may be addressed to Dr. Coant, Cooper Hospital-University Medical Center, Three Cooper Plaza, Camden, NJ 08103.

of these were resistant to gentamycin. Ceftizoxime, in a dose of 200 mg/kg/day, four times a day, intravenously, was added to the regimen. Gentamycin was discontinued two days later.

Sterilization of the CSF was achieved one day after initiating therapy with ceftizoxime intravenously, and remained sterile throughout a 14-day course of treatment. A VP shunt was inserted two weeks after antibiotics treatment. The infection did not recur.

DISCUSSION

Ventriculitis often complicates the treatment of meningitis.¹ In older neonates with meningitis, reported mortality is 4 percent and morbidity is 25 percent.⁷ When ventriculitis occurs, it is difficult to eradicate because the infection occludes the subarachnoid spaces. Penetration of antibiotics is hindered, while new sites are seeded by bacteria.¹ Successful eradication of ventriculitis requires greater antibiotic penetration than that required for meningitis alone. This case illustrates the difficulty in treating gram-negative rod ventriculitis with standard intraventricular gentamycin. Others have shown benefit from intraventricular antibiotics as long as drug levels are monitored carefully.^{1,3} In this case, the intraventricular gentamycin did eradicate the *Klebsiella pneumoniae*, but not the *E. coli*. The latter was sensitive initially to gentamycin, but during therapy, three strains of *E. coli* emerged, and two strains were resistant to gentamycin.

Many other antibiotics, especially cephalosporins, have been proposed in the treatment of gram-negative ventriculitis. However, most antibiotics require sys-

temic and intraventricular therapy.^{5,6,8} Studies by McCracken suggest increased morbidity with the direct intraventricular route for antibiotics.⁴ Antibiotics that reach therapeutic intraventricular levels via the systemic route alone, therefore, would appear to be superior. In this case, ceftizoxime, given entirely intravenously, eradicated the *E. coli*.

SUMMARY

The results of this single case report suggest that ceftizoxime may be an excellent antibiotic in the therapy of *E. coli* meningitis with ventriculitis.

REFERENCES

1. Eeckels R, Corbeel L, De Boeck C, et al: Intraventricular and/or intralumbar treatment of purulent meningitis in infants. *Acta Paediatr Belg* 33:243-251, 1980.
2. Bayston R, Barnicoat M, Cudmore RE, et al: The use of intraventricular vancomycin in the treatment of CSF shunt-associated ventriculitis. *Z Kinderchir* 39:111-113, 1984.
3. Pau A, Smego R, Fisher M: Intraventricular vancomycin: Observations of tolerance and pharmacokinetics in two infants with ventricular shunt infections. *Pediatr Infect Dis* 5:93-96, 1986.
4. McCracken GH, Mize SG, Threlkeld N: Intraventricular gentamycin therapy in gram-negative bacillary meningitis of infancy. *Lancet* 1:787-791, 1980.
5. Mir NA: Ventriculitis complicating pyogenic meningitis in neonates. *Indian J Pediatr* 52:395-400, 1985.
6. Macfarlane DE, Baum-Thureen P, Crandon I: *Flavobacterium odoratum* ventriculitis treated with intraventricular cefotaxime. *J Infect* 11:233-238, 1985.
7. Baumgartner ET, Augustine A, Steele RW: Bacterial meningitis in older neonates. *Am J Dis Child* 137:1052-1054, 1983.
8. Isaacs D, Slack MPE, Wilkinson AR, et al: Successful treatment of *Pseudomonas* ventriculitis with ciprofloxacin. *J Antimicrob Agents Chemother* 17:535-538, 1986.

REVIEW ARTICLE: METHOTREXATE IN THE RHEUMATIC DISEASES

SHELDON D. SOLOMON, M.D., CHERRY HILL*

Methotrexate, a chemotherapeutic agent, is being used in the rheumatic diseases; its pharmacology, method of usage, efficacy, and toxicity are discussed; questions are raised as to its future use.

Methotrexate, a folic acid antagonist and well-known chemotherapeutic drug, first was used to treat the rheumatic diseases in the 1950s.¹ In the early 1970s, immunosuppressive therapy became fashionable for treatment of the rheumatic diseases, particularly rheumatoid arthritis. Over the past five years, methotrexate has received widespread attention as a disease-modifying antirheumatic drug (DMARD). Most rheumatologists are using this drug. Presently, it is not approved by the Food and Drug Administration (FDA).

CLINICAL PHARMACOLOGY

Methotrexate inhibits dihydrofolic acid reductase, the enzyme that reduces folic acid to tetrahydrofolic acid during DNA synthesis. Consequently, methotrexate interferes with cellular reproduction. In general, actively proliferating tissues such as cancer cells, bone marrow tissue, and rheumatoid pannus formation are most sensitive to this effect than others. At present, the mechanism of action of methotrexate is unknown in the rheumatic diseases, but there is a reduction in articular swelling soon after therapy is instituted. Oral absorption seems to be dose-dependent with serum levels peaking at about one to two hours. Food slightly delays the peak and reduces the peak concentration. Methotrexate is approximately 50

percent protein bound in the serum. It may be displaced from plasma albumin by certain other drugs such as salicylates, sulfa compounds, Dilantin®, and coumadin-like drugs. After absorption, it undergoes hepatic and intracellular metabolism to polyglutamated forms and is excreted primarily through the kidneys. Impaired renal function or use of drugs, such as weak organic acids, i.e. aspirin or other anti-inflammatory drugs, markedly can influence methotrexate serum levels. Impaired excretion due to renal insufficiency can lead to high or possibly toxic levels. Excellent correlation occurs between methotrexate and creatinine clearances.

CLINICAL EFFECTIVENESS

Use in rheumatoid arthritis. There now are several open and controlled short-term and long-term trials showing the effectiveness of methotrexate in rheumatoid arthritis. In a double-blind, crossover study comparing methotrexate to placebo, it was significantly better than placebo.² This was a short-term, 24-week study. Significant improvement in the patient's pain, articular index, morning stiffness, and Westergren sedimentation rate was demonstrated by another long-

*Dr. Solomon is co-chief, arthritis unit, West Jersey Health Systems. Correspondence may be addressed to Dr. Solomon, 1860 Greentree Road, Cherry Hill, NJ 08003.

term study (mean of 53 months), where multiple clinical parameters continue to indicate statistically significant improvement from baseline.³ In our long-term open study, 80 patients were followed from 1 to 68 months, with the average being 40.3 months; the three criteria utilized to measure response (mean pain response, improvement in the Westergren sedimentation rate, and reduction in the need for daily doses of prednisone) were excellent with the mean pain response dropping 66 percent, the Westergren sedimentation rate dropping 52 percent, and the reduction in steroids being 61 percent. In addition, 30 percent of patients no longer required concomitant nonsteroidal anti-inflammatory drug therapy.⁴

Other rheumatic diseases. The earliest, most extensive use of methotrexate, other than in malignancy, was in the treatment of psoriasis and psoriatic arthritis. It has been shown to be very effective in psoriatic arthritis, with the earliest double-blind study being performed in 1964.⁵ There have been several case reports of methotrexate being very effective in chronic Reiter's syndrome and polymyositis; although for obvious reasons, double-blind studies have not been completed.

TOXICITY

Minor problems. The most common minor side effects are related to the gastrointestinal system with doses less than 15 mg a week. Nausea, mucositis, and diarrhea have been mild and often intermittent; in most cases, there has not been a need for discontinuance of the drug. An occasional report of moderate alopecia also has been reported with these low doses.

Major problems. Methotrexate's inhibitive effect on cell growth obviously extends to the bone marrow. One often sees megaloblastic changes with macrocytosis on the peripheral smear. Leukopenia occurs frequently, but rarely is serious. In our series, two patients did develop reversible agranulocytosis and sepsis requiring hospitalization. Patients at greater risk of bone marrow suppression are those who may develop higher blood levels of the drug because of renal insufficiency, folate deficiency, or use of concomitant medications such as trimethoprim-sulfa-methoxazole.

Hepatotoxicity also is a major concern with long-term use of methotrexate. This has been seen mainly in patients treated for psoriasis over many years. Liver function studies should be obtained when patients are on medication. Often, liver tests do not correlate with the extent of liver toxicity, so some physicians recommend liver biopsy every two years.⁶ The development of hypoalbuminemia is suggestive of early hepatofibrosis. I do not recommend liver biopsies, except in patients with excessive alcohol ingestion or with persistently progressive liver function enzyme abnormalities. Often with liver function tests up to three times abnormal, I recommend holding the dose for a week or two and then reinstituting it. Usually these effects will disappear, particularly if the patient is warned about not ingesting any alcoholic beverages.

Pulmonary effects. This appears to be a hypersensitivity reaction. There are several reports of pulmonary toxicity with low-dose methotrexate. The patient presents with a nonproductive cough, dyspnea, and fever. Usually an interstitial pneumonitis is seen

on radiographs. Treatment is by removal of the drug and by occasional use of systemic steroids, with excellent improvement.⁷

Methotrexate seems to be an effective agent in the treatment of rheumatoid arthritis; yet there are many questions still to be answered.

Oncogenicity. Other cytotoxic drugs are used in the treatment of patients with nonmalignant conditions such as rheumatic diseases, with the potential of oncogenesis; however, unlike the alkylating agents such as cytoxan, leukeran, or Imuran®, methotrexate has not been shown to be carcinogenic in high-dose or low-dose therapy.^{8,9}

Teratogenicity. Methotrexate certainly is teratogenic when given during the first three months of gestation.¹⁰ It also causes reversible oligospermia.¹¹

METHOD OF USAGE

Methotrexate is taken in weekly "pulse" dosages, i.e. 7.5 mg orally once a week; after four weeks, if no response, increase dosage by 2.5 mg until a maximum of 15 mg weekly. The intramuscular route is utilized for someone who cannot tolerate methotrexate orally because of nausea. A complete blood count, platelet count, and liver and renal function tests are monitored weekly for four weeks and then monthly.

CONCLUSIONS

Methotrexate seems to be an effective agent in the treatment of rheumatoid arthritis. Its effects include slowing the inflammatory process, reducing the potential deformities, and preventing loss of function. However, it certainly is not without risk, and many questions are still to be answered:

1) Is methotrexate just another anti-inflammatory agent such as the NSAIDs? Or is it truly remittive in nature? (In certain patients, it does seem to make the disease process almost disappear, yet once again to later return once the drug is discontinued.)

2) Where should methotrexate be given in the therapeutic ladder? At present, most rheumatologists are using other remittive drugs early in the disease process such as gold therapy, Plaquenil®, or D-penicillamine. However, because of its rapid mode of action and its dramatic effects, some physicians are placing methotrexate higher on their lists and initiating therapy earlier. Studies are needed to compare methotrexate against other remittive drugs.

3) How long can patients be maintained on methotrexate? There still are some questions concerning long-term liver toxicity that have not been answered.

4) Because of its potential lung problems, should methotrexate not be withheld from patients with rheumatoid lung disease? This would exclude a large proportion of patients with rheumatoid arthritis.

5) Does methotrexate help the extra-articular manifestations of rheumatoid arthritis? Once again, the answer to this question is not known. Many patients

have been observed whose nodules seem to worsen while on the drug.

I would suggest that methotrexate be used cautiously and with careful followups in all patients. Patients should be screened for concomitant drug use and alcohol ingestion, and should be followed with serial laboratory studies, CBC, and occasional chest x-ray.

REFERENCES

1. Gubner R: Therapeutic suppression of tissue reactivity effective aminopterin and rheumatoid arthritis. *Am J Med Sci* 122:176-182, 1951.
2. Weinblatt ME, Coblyn JS, Fox DA, et al.: Efficacy of low-dose methotrexate in rheumatoid arthritis. *N Engl J Med* 312:818-823, 1985.
3. Kremer J, Lee J: Long-term prospective study of the use of MTX in RA. Update after a mean of 53 months. *Arthritis Rheum* 31:577-584, 1988.
4. Pullman SW, Solomon, SD: Observational and long-term effects of methotrexate in rheumatoid arthritis. Northeast Meeting American Rheumatism Association, September 1987.
5. Black RO, O'Brien WM, Vanscot EJ, et al.: Methotrexate therapy in psoriatic arthritis: Double-blind study in 21 patients. *JAMA* 189:743-747, 1964.
6. Tugwell P, Bennett K: Methotrexate in rheumatoid arthritis. *Ann Intern Med* 107:418-419, 1987.
7. Claire ST, Rice EW, Snyderman R Jr: Pneumonitis complicating low-dose methotrexate therapy in rheumatoid arthritis. *Arch Intern Med* 145:2034-2038, 1985.
8. Rustin GJS, Rustin F, Dent J, et al.: No increase in second tumors after methotrexate chemotherapy for gestational trophoblastic tumors. *N Engl J Med* 308:473-476, 1983.
9. Nyfors A, Jensen H: Frequency of malignant neoplasms in 248 long-term treated psoriatics—a preliminary study. *Dermatologica* 167:260-261, 1983.
10. Anderson TF: Psoriasis. *Med Clinic N Am* 66:769-794, 1982.
11. Grunnet E, Nyfors A: Studies on human semen and topical corticosteroid-treated and methotrexate-treated psoriatics. *Dermatologica* 154:78-84, 1977.

**HOUSING APPLICATION
HEADQUARTERS HOTEL**

**Sheraton
Meadowlands Hotel**

Sheraton Plaza Drive, Two Meadowlands Plaza-East Rutherford, N.J. 07073
Sheraton Hotels, Inns & Resorts Worldwide
The hospitality people of ITT

**223rd ANNUAL MEETING
MEDICAL SOCIETY OF NEW JERSEY
Thursday, April 27, to Sunday, April 30, 1989**

_____ Single _____ Double Other _____

Please print or type the following information:

**\$95/Single
\$95/Double
6% NJ State
Sales Tax**

NAME _____

ADDRESS _____

CITY _____

STATE _____ ZIP _____

TELEPHONE NUMBER (_____) _____

ARRIVAL DATE _____ DAY _____

DEPARTURE DATE _____ DAY _____

NAME OF SHARING GUEST _____

CHECK IF OFFICIAL DELEGATE ☐ COUNTY: _____

All reservations will be held until 4 P.M. unless guaranteed with a credit card number or first night's deposit.

Card # _____ Type _____ Exp. Date _____

Sheraton Club International Member Number _____

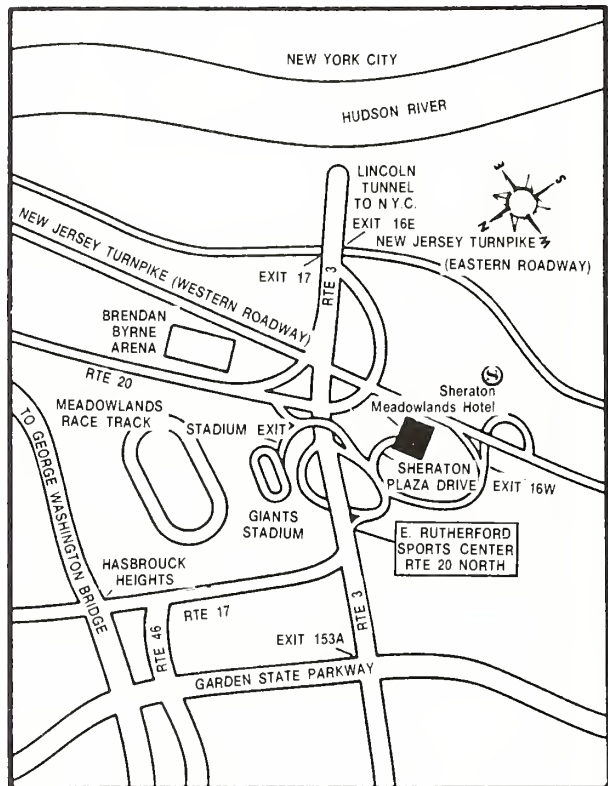
VISA, MASTERCARD, CARTE BLANCHE, AMERICAN EXPRESS, DINERS CLUB & EN ROUTE
CREDIT CARDS ARE ACCEPTED.

MAIL THIS APPLICATION TO:
Reservations
Sheraton Meadowlands Hotel
Sheraton Plaza Drive, Two Meadowlands Plaza
East Rutherford, NJ 07073
Tel: (201) 896-0500

Reservations must be received by April 5, 1989. Those received after cutoff date will be accepted on a space available basis only.

SHERATON MEADOWLANDS HOTEL

How to get to the Sheraton Meadowlands



DOCTORS' NOTEBOOK

Trustees' Minutes; MSNJ Auxiliary; AMNJ Report; Physicians Seeking Location in New Jersey

Trustees' Minutes January 15, 1989

A regular meeting of the Board of Trustees was held on January 15, 1989, at the executive offices in Lawrenceville. A detailed report is on file with the secretary of your county society. A summary of significant actions follows.

Approval of Minutes . . . Noted that the position of the New Jersey Hospital Association on the surcharge issue will be amended to reflect the clarification of Mr. Scibetta's comments: NJHA is attempting to maintain a neutral position on the medical malpractice surcharge proposal, in spite of considerable pressure for the Association to support the proposal.

Report of the President . . . Computerized Severity Index (CSI) . . . Approved transmittal of a letter to the commissioner of health presenting a comprehensive report on the review of CSI and stating MSNJ's position.

Report of Executive Director . . . (1) Membership . . . Noted that there is a slight improvement in the total number of members.

(2) No-Fault Fee Schedule . . . Noted that the medical fee schedule could not be offered for review prior to publication in the *New Jersey Register*.

(3) SBME—Postsurgical Care by Optometrists . . . Directed that a letter be sent to the SBME indicating postsurgical care is the responsibility of the surgeon, and in his absence would be the responsibility of a fully licensed physician designated by the operating surgeon.

(4) MSNJ versus State Board of Physical Therapy . . . Noted that the State Board of Physical Therapy is petitioning the Supreme Court to hear an appeal from the Appellate Division pertaining to a ruling which declared their regulation void.

UMDNJ Report . . . Received a report from Stanley S. Bergen, Jr., M.D., highlighting the following: initiation of an AIDS transmission study of 1,000 heterosexual men and women over a five-year period; rededication of affirmative action; reappointment of Dr. Bergen as president of UMDNJ; appointment of Dr. Paul F. Larson as senior vice-president of academic affairs; celebration of the fifth annual University Day on January 18, 1989; discussion of communication problems between UMDNJ and the New Jersey Academy of Family Physicians will take place at the UMDNJ Board meeting on January 18; and the issue of non-U.S. medical school graduates.

NJ Hospital Association . . . Received a report from Louis Scibetta, highlighting the following: passage of legislation extending the Uncompensated Care Trust Fund for two years; alternatives to obtain the approximate \$181 million 1988 labor reimbursement shortfall; criticisms of the published mortality and morbidity data by HCFA; the report by the National Nurse Advisory Commission attributing the current nursing shortage to increased demand not decreased supply, and its recommendations to address the problem; the reference manual mailed to all 119 New Jersey hospitals entitled, "Guidelines for Meeting the Challenge of AIDS"; replacement of Periodic Interim Payments with the Prospective Payment System for Medicare patients; launching of the statewide Smoke-Free Hospital Campaign on January 18, 1989; and

the 1989 Annual Meeting of the American Hospital Association. In addition, Dr. Robinson asked that the Association reconsider its neutral position on the surcharge proposal.

Council on Legislation . . . Approved the following recommendation:

That the Board of Trustees approve the positions recommended by the Council on Legislation on the action deferred bills.

Also, approved the positions recommended by the Council on Legislation with the exception of A-3781 (requires all health insurers to provide reimbursement for mammograms, pap smears, and infertility tests), where the position was changed to action deferred.

Committee on Membership Services . . . Approved the following recommendation:

That the Equipment Leasing Program offered by Bell Atlantic-TriCon Leasing Corporation be endorsed and offered as an additional service to the Society's membership.

State Board of Medical Examiners . . . Received for its information a report on the January 11, 1989, meeting of the SBME; attention was called to a resolution seeking an amendment to federal confidentiality statutes to provide for access of state licensing boards to patient records and other appropriate information needed by the boards in carrying out their mandate.

New Business . . .

Professional Liability Claims without Merit . . . Voted to reaffirm MSNJ's present mechanism for evaluating malpractice suits, under the direction of Mr. Maressa and Dr. James E. George, director of the Department of Professional Liability Control.

MSNJ Auxiliary

**Angie Campo
President**

At the state level, the Auxiliary has always focused on what we can accomplish in terms of health promotion or legislative action. Our purpose is to provide leadership to

our members and the medical profession.

Legislation is a top priority in these times. We have met on many occasions with lobbyists and legislators locally and in Washington, D.C. We have helped in the passage and defeat of bills that are important to physicians. Our annual trip to Washington in April will find us visiting New Jersey congressmen at their offices, and meeting with Jayne Hart, assistant director, AMA Department of Congressional Relations.

County auxiliaries accomplish much. We do what we can to assist them, but in a real sense, they are autonomous in their programs as they work to meet the needs of their communities. Their energy, talents, and innovative fundraising programs are amazing.

Thousands of young men and women have been given financial assistance through medical and nursing scholarships. Worthy applicants are chosen by the local auxiliary. Over the years, we have pioneered "Careers in Health" at hospital settings and on school campuses. We have convinced many young people

of the rewards and satisfactions of helping others. However, due to the critical shortage of nurses and x-ray technicians, these particular careers are being stressed, and monies are provided for assistance.

Auxiliary members serve on local community health boards, cultural arts organizations, and boards of education; they are well represented at national organizations like the American Lung Association, the Juvenile Diabetes Association, and the American Cancer Society. Members are involved in "Eat Smart" programs promoting good nutrition and high-fiber diets for all ages, and good health habits, as well as the consequences of smoking aimed at school children at all grade levels.

A top priority this year has been for each county to donate supplies and contributions to the families of the Physicians' Health Program. The response has been gratifying, especially during this past holiday season. This commitment will continue.

On behalf of all our hardworking members, I would like to extend my thanks to all the physicians throughout New Jersey for financial

and moral support. Through your generosity, we have accomplished much.

AMNJ Report

Benjamin F. Rush, Jr., M.D.
President

The Academy of Medicine and the Medical Society of New Jersey are sponsoring "Clinical Trials for HIV Infection: What To Do when the HIV Test Is Positive." The program is funded through a grant from the New Jersey State Department of Health, Division of AIDS Prevention and Control. There will be three programs: Thursday, April 27, 1989—1989 MSNJ Annual Meeting, Meadowlands Sheraton Hotel; Tuesday, May 16, 1989—Cherry Hill Inn, Cherry Hill; and Wednesday, May 17, 1989—MSNJ Headquarters, Lawrenceville. Contact Susan Weeast at the Academy, 609/896-1717, for registration information.

Dr. Richard Dixon of the Helene Fuld Medical Center and chairman of the series will address "Standard versus Experimental versus Empirical Treatment: What Is Best for

1989 MSNJ Annual Meeting

The Board of Trustees of the Medical Society of New Jersey at its September 18, 1988, meeting, approved the Committee on Annual Meeting recommendation that the 1989 Annual Meeting be held at the Sheraton Meadowlands Hotel in East Rutherford, on Thursday, April 27, through Sunday, April 30, 1989.

The daily schedule follows:

Wednesday, April 26, 1989

3:30 P.M. Board of Trustees' Meeting

Thursday, April 27, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

10:00 A.M. House of Delegates

11:00 A.M. Exhibits Open

1:00 P.M. Program—Topic of Major Interest to Physicians

3:30 P.M. Reference Committee Meetings

Friday, April 28, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

8:30 A.M. Exhibits Open

9:00 A.M. House of Delegates (Election)

12:00 NOON Golden Merit Award Ceremony and Reception

2:30 P.M. Reference Committee Meetings

5:00 P.M. JEMPAC Political Forum

Friday, April 28, 1989

5:45 P.M. JEMPAC Wine and Cheese Reception

6:30 P.M. Middlesex County Medical Society Reception

Saturday, April 29, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

8:30 A.M. Exhibits Open

9:00 A.M. House of Delegates

1:30 P.M. House of Delegates

2:00 P.M. Exhibits Close

6:00 P.M. Inaugural Reception and Dinner

Sunday, April 30, 1989

8:00 A.M. Registration Opens

8:00 A.M. Message Center Opens

8:30 A.M. General Session—Topic of Major Interest to Physicians

1:00 P.M. Board of Trustees' Meeting

the Patient?" Dr. John Sensakovic of Saint Michael's Medical Center will present "Testing and Counseling for HIV Infection" and Dr. David Gocke of the Robert Wood Johnson Medical School will discuss "Adult Clinical Trials." Dr. Edward Conner of Children's Hospital of New Jersey and the New Jersey Medical School will address "Newborn, Pediatric, and Maternal Clinical Trials." Mr. William Orr will give an overview entitled "Community Treatment Initiatives."

Dr. Paul Volberding, director of AIDS Activities Division, San Francisco General Hospital, will be the keynote speaker for the two May events.

The Academy has entered into an agreement with PICME (Physician Initiated CME) to offer members of the Academy a new and innovative means of gaining AMA/PRA Category 1 CME credit through individualized learning contracts. The physicians can define their own learning needs and those skills they wish to acquire. By using PICME's Guidelines for Development of Independent Contracts, the Academy will coordinate and administer CME projects. For further information, contact Ronnie Davidson, Ed.D. at the Executive Offices.

The Academy will continue the evening dinner format for its First Wednesday series. The next event will be held on Thursday, April 13, 1989, at the Holiday Inn in Livingston. The evening will be co-sponsored by the Essex County Medical Society and the Citizen's Committee on Biomedical Ethics. The topic for discussion will be, "The Role of Ethics Committees in Hospitals—How to Establish Finance." Panelists will include Paul Armstrong, Esq., Dr. Joseph Fennelly, and Dr. John Gregory. Further information can be obtained by contacting the Academy's Executive Offices.

The 1989 schedule for the New Jersey Physicians Golf Association is almost complete and will be mailed to the membership at the end of February. The NJPGA plans to hold six tournaments this year, which will be the third season for the organization. Further information on membership in the NJPGA is available by contacting Lisa Swartek at the Academy's Executive Offices.

Plans are moving forward for the

Academy's Annual Awards Dinner to be held on Wednesday, May 24, 1989, at the Chanticleer in Short Hills. The Awards Committee has sent a solicitation letter to all Academy Fellows and friends requesting support for the Sponsors Book to commemorate the occasion and raise funds for the Academy's Education Fund. Further information on the dinner and this fundraising activity can be obtained by contacting Linda Bartolo at the Executive Offices.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Robert C. Mayer, M.D., 32 Pebble Beach Cir., Glendale Heights, IL 60139. Ross University 1985. Board eligible. Group or partnership. Available.

FAMILY PRACTICE—Tariq H. Butt, M.D., 605 West Madison Ave., #2606, TWR #3, Chicago, IL 60606. Dow (Pakistan) 1980. Board eligible. Group or partnership. Available July 1989.

Eileen Hill, M.D., 155 Briarwood Rd., Mt. Laurel, NJ 08054. Pennsylvania 1980. Board certified. Part time. Available.

Steven Luke, M.D., 111 Hicks St., 9P, Brooklyn, NY 11201. SUNY-Upstate 1982. Also, pediatrics. Board certified. Board eligible (PED). Group. Available.

GASTROENTEROLOGY—Curtis Freeland, D.O., 25601 Briar Dr., Oak Park, MI 48237. Des Moines College of Osteopathic Medicine and Surgery 1981. Board eligible. Group or partnership. Available July 1989.

Robert I. Leventhal, M.D., 1000 J Scaife Hall, Division of Gastroenterology, University of Pittsburgh, Pittsburgh, PA 15217. St. Georges (Grenada) 1984. Board eligible. Consultative, group, partnership, solo. Available July 1989.

HEMATOLOGY—Vijaykumar Gandhi, M.D., 12126 Chapin Apts., SUNY, Stony Brook, NY 11794. Baroda (India) 1981.

Also, internal medicine. Board eligible. Board certified (IM). Group, partnership, solo. Available July 1989.

INTERNAL MEDICINE—Nancy Hsueh Beggs, M.D., 242 East Second Street, Atco, NJ 08004. Temple 1986. Board eligible. Group or multispecialty practice. Available July 1989.

Ezra Bendit, M.D., 22 Mt. Rascal Rd., Hackettstown, NJ. UMDNJ 1984. Board certified. Group or partnership. Available.

Bhuvana Chinnappan, M.D., 139 Wm. Feather Dr., Voorhees, NJ 08043. Board eligible. Group, partnership, solo. Available.

Leon G. DeMasi, M.D., 24 Whitechapel Dr., Mt. Laurel, NJ 08054. Temple 1979. Board eligible. Solo. Available 1989.

Albert S. Ford, M.D., 4 Linden Lane, Scotch Plains, NJ 07076. Meharry (India) 1982. Board eligible. Solo. Available.

Vijaykumar Gandhi, M.D., 12126 Chapin Apts., SUNY, Stony Brook, NY 11794. Baroda (India) 1981. Also, hematology/oncology. Board certified. Board eligible (HEMATOL). Group, partnership, solo. Available July 1989.

Eric B. Hatton, M.D., 800 Rosewood Dr., Clovis, NM 88101. Boston 1982. Board eligible. Group. Available July 1989.

Lalitha B. Iyer, M.D., 35 Winthrop Rd., Edison, NJ 08817. Madras (India) 1980. Board eligible. Group, partnership, emergency room. Available.

Donald Mittrane, M.D., 129 Broadway, Apt. C, Huntington Station, NY 11746. Columbia 1989. Board eligible. Group or partnership. Available July 1989.

OPHTHALMOLOGY—Lawrence Scott Halperin, M.D., 5571-D Waterman, St. Louis, MO 63112. Pennsylvania 1985. Board eligible. Group practice. Available July 1991.

PEDIATRICS—Steven Luke, M.D., 111 Hicks St., 9P, Brooklyn, NY 11201. SUNY-Upstate 1982. Also, family practice. Board eligible. Board certified (FAM MED). Group. Available.

RADIOLOGY—Robert W. Cifers, M.D., 6913 Bonnie Ridge Dr., Apt. T1, Baltimore, MD 21209. Ohio State 1983. Board eligible. Also, nuclear medicine. Group, partnership, solo. Available May 1989.

UROLOGY—David S. Altman, M.D., 402 Laura Dr., Danville, PA 17821. Jefferson 1985. Board eligible. Group, partnership, multispecialty. Available July 1990.

MSNJ ANNUAL MEETING

April 27, 1989-April 30, 1989

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization (indicated in italics) for further information.

ALLERGY

April

- 19 Insect Allergy**
8-9 P.M.—The Manor, West Orange
(*NJ Allergy Society*)

ANESTHESIOLOGY

April

- 5 Neuroanesthesia**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 16 Minimizing Risk in Ob Anesthesia**
Ramada Inn, Clark
(*NJS Society of Anesthesiologists*)

CARDIOLOGY

April

- 5 Pediatric Cardiology Update**
9 A.M.-4:30 P.M.—Deborah Heart and Lung Center, Browns Mills
(*Deborah Heart and Lung Center*)
- 12 Percutaneous Transluminal Coronary Angioplasty**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 19 Thromboembolism and Thrombolytic Therapy**
9-10 A.M.—Warren Hospital, Warren
(*AMNJ*)

May

- 3 Thromboembolism and Thrombolytic Therapy**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(*AMNJ*)

DERMATOLOGY

April

- 11 Dermatological Society of New Jersey**
7-10 P.M.—Schering-Plough

Corporation, Kenilworth
(*Dermatological Society of New Jersey*)

- 12 Dermatological Conferences**
6-9 P.M.—Rutgers Community Health Center, 57 U.S. Highway 1 South, New Brunswick
(*UMDNJ*)
- 14 Common Tumors of the Skin**
12 noon-1 P.M.—Warren Hospital, Warren
(*AMNJ*)

May

- 17 Dermatological Conferences**
6-9 P.M.—Rutgers Community Health Center, 57 U.S. Highway 1 South, New Brunswick
(*UMDNJ*)
- 19 Principles of Dermatological Therapy**
9-10 A.M.—St. Francis Medical Center, Trenton
(*AMNJ*)

INFECTIOUS DISEASES

April

- 3 Clinical Management of HIV Infection**
11:30 A.M.-1 P.M.—East Orange General Hospital, East Orange
(*AMNJ*)
- 5 Counseling and Testing for HIV Infection**
9-10 A.M.—Somerset Medical Center, Somerville
(*AMNJ*)
- 10 Counseling and Testing for HIV Infection**
7:30-8:30 A.M.—Newcomb Medical Center, Vineland
(*AMNJ and NJDOH*)
- 10 Clinical Management of HIV Infection**
1-2 P.M.—Woodbine Developmental Center
(*Woodbine Developmental Center and NJDOH*)
- 17 Counseling and Testing for HIV Infection**
11:30 A.M.-12:30 P.M.—East Orange General Hospital, East Orange
(*AMNJ*)
- 25 Clinical Management of HIV Infection**
8-9 A.M.—Wayne General Hospital, Wayne
(*AMNJ*)
- 28 Counseling and Testing for HIV Infection**
7:30-8:30 A.M.—Atlantic City Medical Center, Atlantic City
(*AMNJ*)

May

- 3 Psychiatric Aspects of AIDS**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(*AMNJ*)
- 24 Clinical Management of HIV Infection**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(*AMNJ and NJDOH*)
- 25 Clinical Management of HIV Infection**

11:45 A.M.-1 P.M.—JFK Medical Center, Edison
(*AMNJ and NJDOH*)

MEDICINE

April

- 4 Pathogenesis and Treatment of Lupus**
11 A.M.-12 noon—St. Joseph's Hospital and Medical Center, Paterson
(*St. Joseph's Hospital and Medical Center*)
- 5 Otto Brandman, M.D., Award Ceremony**
6-10 P.M.—The Hyatt Regency, New Brunswick
(*American Diabetes Association*)
- 5 Malpractice**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(*AMNJ*)
- 5 Inflammatory Bowel Disease**
1:30-2:30 P.M.—HMO, New Brunswick
(*Rutgers Community Health Plan*)
- 11 Medical Grand Rounds**
- 18 Holy Name Hospital, Teaneck**
- 25 (Holy Name Hospital)**
- 12 Nonoperative Management of Chronic Back Pain**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(*AMNJ*)
- 13 First Wednesday at the Academy**
Holiday Inn, Livingston
(*AMNJ*)
- 19 Child Abuse**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(*AMNJ*)
- 19 What the Primary Physician Must Know and Do To Save Diabetic Legs**
12 noon-1 P.M.—Welkind Rehabilitation Hospital, Chester
(*AMNJ*)
- 19 Common ENT Problems**
1:30-2:30 P.M.—HMO, New Brunswick
(*Rutgers Community Health CME Series*)
- 20 Humanism in the Practice of Medicine**
12 noon-1:30 P.M.—Somerset Medical Center, Somerville
(*Somerset Medical Center*)
- 21 Clinicopathological Case Presentation**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(*Bridgeton Hospital*)
- 25 The Misdiagnosed Headache**
7-8 P.M.—Molly Pitcher Inn, Red Bank
(*AMNJ and TMJ Trauma and Headache Center*)
- 27 Visiting Professor Program**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(*Saint Barnabas Medical Center*)
- 27 MSNJ Annual Meeting**
Sheraton Meadowlands Hotel, East Rutherford
(*MSNJ*)

ORAL AND LARYNGEAL CANCER

The third in the Ongoing Series
on Multidisciplinary Management
of the Patient with Cancer.

April 27 and 28

SURGICAL ONCOLOGY III

This third in the series of Surgical Oncology seminars at Fox Chase Cancer Center will explore innovations in treatment techniques of oral and laryngeal cancers. National experts will conduct lectures and workshops focusing on the integration of multiple disciplines. There will be opportunity to exchange knowledge and experiences.

For more information and reservations, please call Kathy Smith at 215-728-2715.

FOX CHASE
CANCER CENTER

7701 Burholme Avenue Phila., PA 19111

As an organization accredited by the Accreditation Council for Continuing Medical Education, Temple University School of Medicine certifies that this program meets the criteria for 8.5 credit hours of Category I, provided it is completed as designed.

Surgical Oncology IV to be held NOV. '89

May

- 3 Psychiatric Aspects of AIDS**
10:30-11:30 A.M.—Christ Hospital,
Jersey City
(AMNJ)
- 5 Update on Medical Liability Issues**
12 noon-1 P.M.—Bridgeton Hospital,
Bridgeton
(Bridgeton Hospital)
- 8 Early Office Recognition of Depression**
7-8 P.M.—Wallkill Valley General
Hospital, Sussex
(AMNJ)
- 11 Annual Meeting**
Trump Plaza, Atlantic City
(American College of Emergency
Physicians, NJ Chapter)
- 12 New Laboratory Diagnostic Tests**
12 noon-1 P.M.—Bridgeton Hospital,
Bridgeton
(Bridgeton Hospital)
- 12 Hyperalimentation**
1:30-2:30 P.M.—Vineland
Developmental Center, Vineland
(AMNJ)
- 15-16 Princeton Liposome Conference**
8 A.M.—Scanticon Conference
Center, Princeton
(Liposome Company, Inc.)
- 18 How To Live To Be 100**
12 noon-1 P.M.—Somerset Medical
Center, Somerville
(Somerset Medical Center)
- 19 Lipids, Stress, and the Heart**
12 noon-1 P.M.—Bridgeton Hospital,
Bridgeton
(Bridgeton Hospital)
- 23 The Misdiagnosed Headache**
7-8 P.M.—Molly Pitcher Inn,
Red Bank
(AMNJ and TMJ Trauma and
Headache Center)
- 24 Intensive Review of Medicine**
8:30-10 A.M.—Alexian Brothers
Hospital, Elizabeth
(Cornell University Medical
College and the National
Institutes of Health)
- 25 What the Primary Physician Must Know and Do To Save Diabetic Legs**
9-10 A.M.—Dover General Hospital
and Medical Center
(AMNJ)
- 25 Visiting Professor Program**
1:30-5 P.M.—Saint Barnabas
Medical Center, Livingston
(Saint Barnabas Medical Center)

NEPHROLOGY**April**

- 12 Renal Symposium**
9 A.M.-5 P.M.—Community Medical
Center, Toms River
(Community Medical Center)
- 18 Pathophysiology of Metabolic Alkalosis**
6:30-9:30 P.M.—Overlook Hospital,
Summit
(Nephrology Society of NJ)
- 19 Chronic Renal Failure**
10:30-11:30 P.M.—St. Mary's
Hospital, Passaic
(AMNJ)

May

- 16 Mechanisms of Progression of Chronic Renal Failure**
6:30-9 P.M.—Overlook Hospital,
Summit
(Nephrology Society of NJ)

ONCOLOGY**April**

- 6 Cancer Research Colloquium**
13 3-4 P.M.—New Jersey Medical
School, G-506B, Newark
27 (UMDNJ)
- 25 Tumor Conference**
12 noon-1 P.M.—Community
Medical Center, Toms River
(Community Medical Center)

May

- 4 Cancer Research Colloquium**
11 3-4 P.M.—New Jersey Medical
School, G-506B, Newark
18 (UMDNJ)
- 25 Conservative Management of Breast Cancer**
10:30-11:30 A.M.—Christ Hospital,
Jersey City
(Christ Hospital)
- 26 Head and Neck Cancer**
7:30-8:30 A.M.—Atlantic City
Medical Center, Atlantic City
(AMNJ)

ORTHOPEDICS**April**

- 12 Nonoperative Management of Chronic Back Pain**
10:30-11:30 A.M.—Christ Hospital,
Jersey City
(AMNJ)

PATHOLOGY**May**

- 13 Current Trends in Pathology—1989**
9 A.M.-5 P.M.—Somerset Marriott
Hotel, Somerset
(NJ Society of Pathologists)

PEDIATRICS**April**

- 19 Child Abuse**
10:30-11:30 A.M.—Christ Hospital,
Jersey City
(AMNJ)
- 28 New Issues in Pediatrics**
12 noon-1 P.M.—Bridgeton Hospital,
Bridgeton
(Bridgeton Hospital)

PSYCHIATRY**April**

- 5 Case Seminars To Improve Psychotherapeutic Technique**
8-10 P.M.—2 West Northfield Road,
Livingston
(Advanced Psychiatric Study
Group)
- 5 Anxiety Disorders**
1:30-2:30 P.M.—Essex County
Hospital Center, Cedar Grove
(AMNJ)
- 6 Biology of Personality**
12 noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)
- 7 Lecture Series**
14 1:30-3:45 P.M.—Trenton Psychiatric
Hospital, Trenton
21 (Trenton Psychiatric Hospital)

**NEW JERSEY
MEDICINE****OPPORTUNITIES**

**“CME
Pages 221-230”**

VERBAL THRESHOLD AND THE NEW JERSEY PHYSICIAN:

Evaluating and Treating Patients Under the New Verbal Threshold Law.

New Jersey's new automobile legislation impacts physicians.
Learn how to protect your medical fees under the new law at
this year's most important seminar.

**The Meeting Place, Riverside Square Mall,
Route 4, Hackensack, N.J.**

Tuesday, March 14, 1989, 6 p.m.-10 p.m.

FACULTY:

Samuel L. Davis, Esq.—Davis, Saperstein & Salomon, P.C., Hackensack, N.J.
David V. Habif, Jr., M.D.—Teaneck Radiology Center, Teaneck, N.J.
David M. Myers, M.D.—Orthopaedic Surgeon, Private Practice.



**THE
LEGAL
INSTITUTE
FOR
MEDICAL
EDUCATION**

"The Academy of Medicine of
New Jersey designates this
continuing medical education
program for 3 hours in Category
I for the Physician's Recognition
Award of the American Medical
Association."

Registration—Enrollment limited. Reserve now to ensure participation.
Tuition for seminar including materials and catered dinner.

Advance Registration and Program Materials	\$125.00
Door Registration and Program Materials	155.00
Audio Cassette Tapes (with Registration)	25.00
Audio Cassette Tapes	45.00
Audio Cassette Tapes and Program Materials	95.00
Video Cassette Tapes and Program Materials	\$125.00
Office Manager Registration	25.00

Physician Name _____

Street _____ City/State/Zip _____

Business Phone (_____) _____

Office Manager Name _____

I cannot attend, but send materials as indicated above. _____

Payment: Check Amount \$ _____ Master Card/Visa # _____

Send check and registration form to: Legal Institute For Medical Education (L.I.M.E.), 211 Essex Street, Suite
306, Hackensack, N.J. 07601 (201) 342-9362

ATTENTION PRIMARY CARE PHYSICIANS INCREASE YOUR SKILLS Accredited 16 Hours AAFP, AMA, AOA (Category I)

ATTEND . . . Procedural Skills for Primary Care Physicians **FEE: \$375**

LEARN . . . Allergy testing, audiometry, cryosurgery, dermatologic procedures, flexible sigmoidoscopy, holter monitoring, joint injection techniques, nasopharyngoscopy, pulmonary function testing, vascular flow testing, including an introduction to colposcopy and office ultrasonography.

FEE: \$375

LOCATIONS - DATES

PHOENIX	PHILADELPHIA	CLEVELAND	ST. LOUIS
March 18-19, 1989	April 15-16, 1989	May 6-7, 1989	June 16-17, 1989

COLPOSCOPY — CARDIAC STRESS TESTING

(one day devoted to each — attend either or both)

SPECIAL PROGRAM — NEW ORLEANS — APRIL 29-30, 1989

During The New Orleans Jazz Festival Week

A FULL DAY WILL BE DEVOTED TO EACH TOPIC, WITH BOTH LAB & LECTURE

Tuition: \$295/program (\$525 if registered for both days)

TAKE A TAX DEDUCTIBLE VACATION

Attend A Medical Malpractice Risk Management Seminar & Receive
AMA Category 1 CME Credit — Programs Available Weekly At:

Disney World • Steamboat Springs, CO • North Conway, NH • Nassau
AND 5 CLUB MED VILLAGES AT:

Copper Mtn, CO • Port St. Lucie, FL • Paradise Island, Bahamas
Huatulco, Mexico • Punta Cana, Dominican Republic

CALL Or WRITE

CURRENT CONCEPT SEMINARS • 3301 Johnson Street • Hollywood, Florida 33021
(305) 966-1009 • (800) 225-0227+991-1911

2 Day Program: \$125.00 / 5 Day Program: \$225.00 (Spouse Free)

- 12 Terrorism—Natural Disaster—Abuse—War: The Activation of Post-traumatic Stress Disorders**
All day—Carrier Foundation, Belle Mead
(Carrier Foundation)
- 13 Brain Function in Schizophrenia**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)
- 20 Rape and Incest**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)
- 20 Dementia**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)
- May**
- 1 Schizophrenia**
8:30 A.M.-12:30 P.M.—Center for Health Affairs, Princeton
(Division of Mental Health and Hospitals)
- 3 Case Seminars To Improve Psychotherapeutic Technique**
8-10 P.M.—2 West Northfield Road, Livingston
(Advanced Psychiatric Study Group)
- 4 The View from Middle Age**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)
- 5 Lecture Series**
19 1:30-3:45 P.M.—Trenton Psychiatric Hospital, Trenton
26 (Trenton Psychiatric Hospital)
- 10 The Violent Hand**
All day—Carrier Foundation, Belle Mead
(Carrier Foundation)
- 18 Patients' Experience of Illness through Photography**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)
- 25 Panic Disorder**
12 noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

PULMONARY

April

- 4 Pulmonary Conferences**
11 8-9 A.M.—New Jersey Medical School, H-349, Newark
18 (UMDNJ)
- 4 Pulmonary Case Conferences**
11 8-9 A.M.—University Hospital, New Brunswick
18 (UMDNJ)

May

- 2 Pulmonary Conferences**
9 8-9 A.M.—New Jersey Medical School, H-349, Newark
16 (UMDNJ)
- 23 Pulmonary Case Conferences**
9 8-9 A.M.—University Hospital, New Brunswick
16 (UMDNJ)

RADIOLOGY

April

- 4 Pediatric Radiology**
6-9:30 P.M.—The Meeting Place, Riverside Square Mall, Hackensack
(Teaneck Radiology Center)
- 13 Radiological Society of New Jersey Meeting**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of NJ and AMNJ)
- 14 Update in Diagnostic Radiology**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(Bridgeton Hospital)

May

- 18 Radiological Society of New Jersey Meeting**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of NJ and AMNJ)
- 31 Radiology Meeting**
6:30-10 P.M.—The Manor, West Orange
(AMNJ)

SURGERY AND SURGICAL SPECIALTIES

April

- 4 Surgical Grand Rounds**
11 7-9 A.M.—Hackensack Medical Center, Hackensack
18 (Hackensack Medical Center)
- 7 Update on Laser Surgery**
12 noon-1 P.M.—Bridgeton Hospital, Bridgeton
(Bridgeton Hospital)
- 25 Surgical Intra-abdominal Infections**

8-10 P.M.—Englewood Club, Englewood
(Englewood Surgical Society)

May

- 2 Surgical Grand Rounds**
9 7-9 A.M.—Hackensack Medical Center, Hackensack
16 (Hackensack Medical Center)
- 23 Surgery—Continenence Preserving Operations for Ulcerative Colitis and Familial Polyposis**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)
- 4- Third Annual Meeting**
7 Southhampton Princess Hotel, Bermuda
(Eastern Vascular Society)
- 10 Conservative Management for Breast Cancer**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)
- 23 Head and Neck Surgery**
8-10 P.M.—Englewood Club, Englewood
(Englewood Surgical Society)

UROLOGY

May

- 10 Urology Rounds**
6:20-8:30 P.M.—Robert Wood Johnson Medical School, 108B, New Brunswick
(UMDNJ)
- 10 Urology**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

1989 MSNJ ANNUAL MEETING

The Board of Trustees of the Medical Society of New Jersey approved the Committee on Annual Meeting recommendation that the 1989 Annual Meeting be held at the Sheraton Meadowlands Hotel in East Rutherford, on Thursday, April 27, 1989, through Sunday, April 30, 1989.

Thursday

- 8:00 A.M. Registration Opens
11:00 A.M. Exhibits Open
1:00 P.M. Program for physicians
3:30 P.M. Reference Committee Meetings

Friday

- 8:00 A.M. Registration Opens
8:30 A.M. Exhibits Open
9:00 A.M. House of Delegates
2:30 P.M. Reference Committee Meetings
5:00 P.M. JEMPAC Forum

Saturday

- 8:00 A.M. Registration Opens
8:30 A.M. Exhibits Open
9:00 A.M. House of Delegates
1:30 P.M. House of Delegates
6:00 P.M. Inaugural Reception and Dinner

Sunday

- 8:00 A.M. Registration Opens
8:30 A.M. General Program

INTERNATIONAL CONFERENCES™

1989 CME CRUISE/CONFERENCES ON MEDICO-LEGAL ISSUES & RISK MANAGEMENT—Caribbean, Mexico, Alaska/Canada, China/Orient, Scandinavia/Russia, Mediterranean, Black Sea, Trans Panama Canal. Approved for 24-28 CME Category 1 Credits (AMA/PRA) and AAFP prescribed credits. Excellent group rates on finest ships. Pre-scheduled in compliance with IRS requirements.

Information: **International Conferences**, 189 Lodge Ave., Huntington Station, NY 11746. (800) 521-0076 or (516) 549-0869.

June 12-16, 1989

Update Your Medicine 1989. Association of Practicing Physicians of the New York Hospital and Cornell University Medical College. 33½ hour Category I credit (39 if optional workshops are taken). One week review of all subspecialties of internal medicine. Eight major two-hour symposia, nine-hour review lectures, and Medical Ground Rounds. Four workshops will be given for practical problems and management techniques. Optional workshops sessions on Breast/Pelvic and Male Genitoretal examinations. Held at the **New York Hospital-Cornell** 1300 York Avenue at 69th Street, New York. Information: Office of CME, 212-746-4752, or write Rm D-115. Dr. Lila A. Wallis is Course Director.

GARLIC, ASPIRIN AND A GLASS OF WINE

MEETING THE PUBLIC'S CHALLENGE: PREVENTIVE MEDICINE FOR THE 90's

APRIL 7 & 8, 1989

CLARIDGE CASINO HOTEL
Atlantic City, New Jersey

**Keynote Speakers: Linus Pauling, Ph.D
Benjamin Spock, M.D.**

PRACTICAL INSIGHTS ABOUT:

- ★ Cardiovascular Disease ★ Psychiatric Issues
- ★ Impact of the Environment ★ Communicable Disease

20 CATEGORY I A.M.A. CREDITS

SPONSORED BY:

Cooper Hospital/University Medical Center
The Clinical Campus for the University of Medicine and Dentistry of New Jersey/
Robert Wood Johnson Medical School at Camden

FOR FURTHER INFORMATION:

Ryna Alexander, Office of Continuing Medical Education
Cooper Hospital/University Medical Center
One Cooper Plaza, Camden, New Jersey 08103
(609) 342-3074

SEMINAR ON PREMATURITY

Presented by

**Department of Obstetrics and Gynecology
St. Joseph's Hospital and Medical Center**

Campus of

**Seton Hall University School of
Graduate Medical Education**

**Friday, April 7, 1989
8:30 A.M.-4:30 P.M.**

**Saddle Brook Marriott
Saddle Brook, N.J.**

"Prematurity and Infections"

Joan A. Regan, M.D.

"Assessment, Intervention and Prevention of Prematurity"

Calvin J. Hobel, M.D.

"Fetal Asphyxia— When Does Damage Occur?"

Louis Gluck, M.D.

"Ante and Intrapartum Monitoring of the Premature Infant"

Roy H. Petrie, M.D.

"Pharmacologic Treatment of Preterm Labor"

Steve N. Caritis, M.D.

For additional information and registration,
please contact:

**Faye Giesmann, R.N.
Seton Perinatal Center
St. Joseph's Hospital and Medical Center
703 Main Street
Paterson, N.J. 07503
Tel: 201-977-2034 or 2213.**

LETTERS TO THE EDITOR

A Call for Letters

Dear Doctor Slobodien:

I am pleased that *NEW JERSEY MEDICINE* has an editor who is both willing and significantly courageous to express provocative opinions.

Indeed, I do disagree with many of the editor's opinions, but I think we have made some progress in awakening the slumbering Medical Society when the editor articulates and expounds a defined position.

I would suggest that contrary and opposing comments be solicited and published with the editor's opinion rather than find expression in a later published letter, and that both editor and contributor frankly state any membership or financial interest in favored companies or organizations.

I believe we must address an enormous agenda of ideas, concepts, and issues to reassert our vibrant interests.

(signed) Stanley I. Rossen, M.D.

Dear Doctor Rossen:

Thank you for the kind remarks. Yes, it has been our intention to stimulate correspondence from you, the reader. Consider this as an additional call for comments and criticism, whether positive, negative, or indifferent.

When we receive such a missive, the author of the article that prompted the reply will be asked to respond, post haste, so we may provide timely dialogue. The usual delays between receipt and publi-

cation, of course, must be considered, so we urge you to write as soon as your thought processes and word processors can be activated.

The editor concedes a certain bias in favor of MSNJ and its offspring, the Medical Inter-Insurance Exchange of New Jersey; he knows of no other "conflicts." But we get sinking feelings from the plethora of smothering regulations from all sides and that makes us pause when you ask that contributors unburden themselves and confess to potential bias or favoritism. This is unwarranted, and bias has a way of showing itself without need for documentation.

(signed) Howard D. Slobodien, M.D.
Editor-in-Chief

Laparoscopy; Manual for Staging of Cancer

Laparoscopy

Jean W. Saleh, M.D. Philadelphia, PA, W.B. Saunders Company, 1988. Pp. 276. (\$70)

The author is a laparoscopist-internist who has drawn upon his rich and varied experiences in Paris and New York to present a thorough coverage of every aspect of laparoscopy in clinical and academic medicine. He has enlisted the services of Dr. Robert Neuwirth to write the chapter on gynecologic laparoscopy, the single most frequently performed gynecologic procedure in this country today (except for curettages), performed at least ten times more frequently than nongynecologic laparoscopy.

Although the material is clearly presented and beautifully illustrated (covering indications, techniques, and potential complications), the value of nongynecologic laparoscopy still seems very limited. It is difficult to imagine that a busy

internist, however well-trained in laparoscopy, even with a well-equipped and well-staffed laparoscopy room, will elect diagnostic laparoscopy as long as ultrasonography and computed tomography scans will provide practically the same information at much less risk. The vast majority of patients, certainly in this Middle Atlantic area, will find such radiologic facilities within an hour's drive.

Laparoscopy is an excellent training and teaching modality—there is no better way to visualize the abdominal cavity and its contents—but as a practical clinical tool for nongynecologic purposes, its indications seem more theoretical than practical. To paraphrase Samuel Johnson who observed a circus dog walking on his hind legs, it is not a question of how well he's doing it, but why is he doing it at all. The only feasible answer in this case is to show other dogs that it can be done.

Jerome Abrams, M.D., M.P.H.

Manual for Staging of Cancer. Third Edition.

Oliver H. Beahrs, M.D., Donald Earl Hensen, M.D., Robert V.P. Hutter, M.D., Max H. Myers, Ph.D., (eds). Philadelphia, PA, J.B. Lippincott Co., 1988. Pp. 256. (\$24.50)

Proper classification and staging of cancer permits the physician to determine appropriate treatment, to evaluate management reliably, and to compare worldwide statistics in a logical and consistent way. The third edition of this manual provides much pertinent available information on cancer staging at various anatomic sites as developed by the American Joint Committee on Cancer in cooperation with the TNM Committee of the International Union Against Cancer. These two organizations now have reached uniformity in their staging recommendations so that there is worldwide

agreement on a single system of cancer staging.

Whereas the basis for staging for most cancers is anatomic, the editors concede that as new information becomes known regarding etiology and natural history, the approach to staging may require modification to reflect changes in our understanding of malignant disease and in its management. Factors, such as the extent of differentiation of a tumor and age of the patient, may be important in establishing clinically useful staging systems.

The first part of the manual is devoted to narratives related to the purposes and principles of staging, the philosophy of classification using the TNM system, and general rules regarding the staging of cancer. The use of specific cancer staging forms used for recording data also is described. Another chapter discusses methods of reporting cancer survival and end results, and includes a brief survey of statistical methods applied in the analysis of cancer experience. The bulk of the manual is devoted to the specific staging methods related to anatomic areas, including head and neck, digestive system, lung, breast, and gynecologic and genitourinary sites. In addition, several of the less common cancers are considered. The section on brain tumors takes into consideration the more important aspects of histopathology. There are also sections on Hodgkin's disease and non-Hodgkin's lymphoma and pediatric cancers. What is not included is information relating to the classification and staging of leukemias; it appears the American Joint Committee on Cancer has not yet addressed this issue.

Overall, the manual is extremely useful and should continue to be of great value to physicians, and tumor registrars in their analysis of cancer statistics.

Alan J. Lippman, M.D.

OBITUARIES

**Drs. Ferriss; Gadek;
Giannini; Murray; Naden;
Pinderhughes; Rubens;
Sasso**

Dr. Ruth B. Ferriss

Ruth Bridgman Ferriss, M.D., a retired member of our Morris County component, died at the age of 86. Born in Madison, Dr. Ferriss earned her medical degree at Cornell University Medical College, New York, in 1929; she completed her internship at Wilkes Barre General Hospital, Pennsylvania, and the New York Infirmary for Women and Children. In 1931, she established a family practice in Morristown, where she worked until her retirement in 1972. During her career, Dr. Ferriss was affiliated with Morristown Memorial Hospital, Overlook Hospital, Summit, and All Souls Community Hospital, Morristown. Dr. Ferriss received MSNJ's Golden Merit Award in 1979 for her years of medical service.

Dr. Stanley A. Gadek

Retired general practitioner Stanley Anthony Gadek, M.D., died on October 20, 1988. Born in 1911 in Perth Amboy, Dr. Gadek received his

medical degree at Georgetown University School of Medicine, Washington, D.C., in 1937, and was licensed in New Jersey in 1938. In 1960, he was elected the 145th president of Middlesex County Medical Society, of which he was a member. Dr. Gadek served in the U.S. Army medical corps during World War II, attaining the rank of colonel. A 1987 recipient of MSNJ's Golden Merit Award, Dr. Gadek was a member of the American Medical Association.

Dr. Salvatore J. Giannini

Salvatore Joseph Giannini, M.D., attending physician of surgery and vascular surgery at Greater Paterson General Hospital, died on October 10, 1988. Born in 1923 in New York, Dr. Giannini was graduated from University of Palermo Medical School, Italy, in 1950. Dr. Giannini was director of the intensive care unit in 1968, director of intermediate care in 1973, president of the medical board and staff, and executive committee member at Greater Paterson General Hospital. In addition, he was attending surgeon at St. Joseph's Medical Center, Paterson, and the Chilton Memorial Hospital, Pompton Plains. Dr. Giannini was a member of our Passaic County component and of the American Medical Association.

Dr. William F. Murray

A member of our Middlesex County component, William Francis Murray, M.D., died on October 5, 1988. Born in 1909 in Perth Amboy, Dr. Murray received his medical degree from Long Island College of Medicine, New York, in 1934; he was awarded his license to practice in New Jersey in 1951. A general surgeon, Dr. Murray was affiliated with Perth Amboy General Hospital. He was a member of the American Medical Association, a fellow of the American College of Surgeons, and a diplomate of the American Board of Surgeons.

Dr. Randall S. Naden

Word has been received of the death of Randall Stedman Naden, M.D., a member of our Camden County component. Born in 1927, Dr. Naden earned his medical degree at Jefferson Medical College, Philadelphia, in 1957. Dr. Naden was a

member of the American Medical Association, a diplomate of the American Board of Internal Medicine, and on staff at Cooper Medical Center, Camden, and Garden State Community Hospital, Marlton.

Dr. John L. Pinderhughes

Word has been received of the death of John Lloyd Pinderhughes, M.D., in May 1987. Born in 1921, Dr. Pinderhughes received his medical degree in 1946 from Howard University College of Medicine, Washington, D.C. An internist, Dr. Pinderhughes was affiliated with Clara Maass Medical Center, Belleville; Newark Beth Israel Medical Center; and Martland Medical Center, Newark. Dr. Pinderhughes was a member of our Essex County component and of the American Medical Association; he was a diplomate of the American Board of Internal Medicine; and was active in the American Heart Association on a national and state level.

Dr. Otto Rubens

Otto Rubens, M.D., a retired member of our Morris County component, died on October 7, 1988. A general practitioner, Dr. Rubens was affiliated with St. Clare's Riverside Memorial Hospital, Denville, during his lengthy career. Born in 1902 in Germany, he received his medical degree in 1927 from Freiburg Medical School in his native land; he was awarded a license to practice in New Jersey in 1938. Dr. Rubens was a member of the American Medical Association.

Dr. Albert Sasso

A member of our Essex County component, Albert Sasso, M.D., died on October 1, 1988. Born in 1906, Dr. Sasso was awarded his medical degree from Syracuse University Medical School, New York, in 1930. He completed an internship at St. Michael's Hospital, Newark, in 1931, and received his license to practice in New Jersey later that year. Dr. Sasso was an attending surgeon at St. Michael's Hospital, Newark, and an assistant clinical professor of surgery at UMDNJ-New Jersey Medical School, Newark. He was a fellow of the American College of Surgeons and a member of the American Medical Association.

AUTHOR INFORMATION

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. The goals are educational and informational. All material published in NEW JERSEY MEDICINE is copyrighted by MSNJ.

CONTENT

The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports based on unusual clinical experiences; review articles; clinical notes, succinct items on some aspect or new observation or technique of a case experience; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and an opinion column. Editorials are prepared by the Editor and by guest contributors on timely and relevant subjects; editorials are the responsibility of the author. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the Editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable

manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statement accompanying material offered to *New Jersey Medicine* must contain the following language and must be signed by all authors:

"In consideration of *New Jersey Medicine* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *New Jersey Medicine*.

SPECIFICATIONS

Submit two **manuscripts** that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods used in articles should be identified. Acknowledgements will be made only for specific preparation of an essential part of the manuscript.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The **title page** should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 40-word **abstract** to be used at the beginning of the article.

Tables must be typewritten and double-spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the

source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The **summary** of the article should not exceed 250 words; it should contain only essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

PUBLICATION POLICY

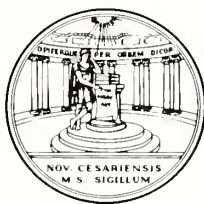
Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Editorial Board. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors.

REPRINT ORDERS

Reprints may be ordered after the author is notified that the article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *New Jersey Medicine*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.



MSNJ NEWSLETTER

EDITOR'S NOTE: OUR JOURNAL

The special article in this issue by Geraldine Hutner points out the previous and current changes in the format of *NEW JERSEY MEDICINE (NJM)*, intended to improve the readability and the attractiveness of the journal. She also delineates many of the varied emphases and philosophies expressed by the editors through the years. Each of the editors has contributed uniquely to the development of today's *NJM*, consonant with a continually changing medical environment.

But, as a regional publication, this magazine has maintained some constants that may have differed from those of national periodicals. All of the editors have recognized this. As expressed by Dr. Reik, "This is, really, your journal." Dr. English also asked for input from the membership. And Drs. Overton and Krosnick also emphasized the interplay between the staff and the readers. The lessons of the past are not lost upon us. As the Gallic phrase states, "Plus ça change, plus c'est mîme chose" (the more things change, the more they stay the same). Note the familiarity of some of the reasons for becoming a monthly, as noted in the first volume of *The Journal* in 1904: to enlist the interest of New Jersey physicians; to provide better communication among the members, inducing them to participate; to promote a higher quality of scientific work and to publish the results; and to aid other organizations, e.g. state and local health boards, the State Board of Medical Examiners.

We are fortunate to have the high level of dedication and competence in all who participate in the creation of this magazine—the full-time *NJM* staff, the Committee on Publication, the Editorial Board, the consultants, and the staff of MSNJ. The amount and the quality of work put out by the small cadre in MSNJ never fails to amaze me, especially when we compare our numbers to those in other state and national groups. (You may send your kudos to those listed on the masthead.) Despite the comments of Dr. Reik, this is not solely your journal, it is our journal. You must do your part by submitting the raw materials—the editorials, articles, and letters. We shall do our best to refine and to insure the continuing quality of these materials, to maintain the nationally recognized excellence of *NEW JERSEY MEDICINE*.

MALPRACTICE SURCHARGE PROPOSAL

In a February 27, 1989, letter to the commissioner of insurance, Judge Herbert Stern (special counsel to MSNJ), pointed out that the commissioner's proposal, as well as the somewhat modified hearing officer's report, violates current state statutes as well as the federal constitution. Judge Stern asserted that the commissioner's authority to issue a surcharge is confined to the establishment of the Malpractice Recovery Fund and cannot be extended to replenish a deficit in that Fund. He also advised that there are two lawful options under state law. Both involve an assessment against liability insurers and not individual policyholders. Those carriers subsequently may be authorized to pass that cost on to policyholders. Because of its impact, the entire text of that letter, a public document, is reprinted.

Dear Commissioner Merin: We represent MSNJ. We have been advised by the Attorney General's Office that you are accepting comments on Officer Bakke's report regarding proposed Rule N.J.A.C. 11:18. The following is a brief summary of the MSNJ's views:

While the Bakke report recognizes the inequity of the Department's rule as originally proposed, its attempt to resolve this inequity is itself unfair. Moreover, it is not supported by statutory authority.

Officer Bakke's proposal to surcharge Association insureds 5 percent, insured hospitals 3.7 percent, and other doctors and hospitals 2.5 percent constitutes a completely arbitrary resolution to this matter. These are random selections. The selections cannot pass a "rational relationship" test. The rule as proposed would unfairly surcharge doctors who prudently paid more in premiums in the past to make up for the unrealistically low premiums paid by other doctors who elected to be covered by the Association. Even doctors who were not in practice at the time and who could make no election also are to be surcharged, while doctors who carry no insurance at this time will pay nothing—even though they may have benefitted from the unrealistically low premiums of the Association in the past.

Officer Bakke recognized these unfairnesses and rejected the proposal that all insured doctors pay equal surcharges.

However, if the Bakke proposal is adopted, individuals who received absolutely no benefit from the Association and its activities (such as doctors who began their practice after the Association ceased to operate, doctors who recently have moved into the state from other states, and doctors who elected to pay substantially higher premiums to the Association's competitor, MIENJ), will be unconstitutionally surcharged to pay for the state's errors in the operation of the Association. While it is true that the Bakke proposal shrinks that surcharge from 5 percent to 2.5 percent, there is no rational reason for 2.5 percent rather than 1 percent or, for that matter, .5 of 1 percent. Indeed, there is no rational reason for such physicians to be singled out to pay anything.

In addition to the constitutional equal protection and due process concerns, and the patent inequity of the proposal, the commissioner does not have the statutory authority to do what the proposal suggests.

N.J.S.A. 17:30D-10 specifically limits the commissioner's power to surcharge insureds to the ability to "establish" a fund to back up the Association's plan of operation. It does not convey the power to surcharge insureds to rescue an existing fund which has fallen into distress.

Indeed, in 1978, the Legislature made it clear that this provision does not authorize the commissioner, after the Association is operating, to surcharge medical malpractice liability insureds to make up a deficit, when it rejected a proposed amendment which sought to give the commissioner just such authority. At the same time that it rejected the proposed amendment to give the commissioner power to surcharge, the Legislature adopted an amendment to 17:30D-3 which empowered the "Association" to assess members (meaning all property and liability insurers as defined in Section 17:30D-2) for deficits according to a specific formula based upon the net direct premiums written by each member. Therefore, to the extent there is any power to surcharge anyone under this situation, the power lies exclusively with the Association, not the commissioner, such assessments must be made upon all member insurers, not insureds, and then only on the basis of the statutory formula. Simply put, in 1978 the Legislature clearly demonstrated that it did not intend to give the commissioner the power to do what Officer Bakke proposes.

However, we do not write merely to object to what has been proposed. We recognize that there is a real problem created by the distress of the Association. We believe that there is a solution to that problem which is not only fair but also clearly within the commissioner's power, a solution specifically authorized by statutes directed to just this situation.

In 1974, the Legislature created the New Jersey Property-Liability Guarantee Association and Fund. (See N.J.S.A. 17:30A et seq.) This Fund is an all-purpose fund which was created by the Legislature specifically to provide a source of funds for insolvent insurers that are unable to pay outstanding claims. The Fund provides that any insurer who directly writes insurance in New Jersey and is licensed or authorized pursuant to Chapter 17 to write insurance in New Jersey, is a member of the Association subject to assessments by the Fund, and in the event it becomes insolvent, may look to the Fund

to pay its outstanding claims. (See N.J.S.A. 17:30A-2 through N.J.S.A. 17:30A-5.)

The New Jersey Malpractice Reinsurance Association is an insurer that provided direct insurance and is authorized under Section 17 to write insurance in New Jersey. Therefore, it is a member of the Guarantee Association and is subject to assessments under Section 17:30A. In fact, the Association has paid substantial monies into the Guarantee Fund since 1978. Moreover, all insured doctors insured by both the Association and the Exchange, have been paying into the Guarantee fund since its inception as a result of surcharges on their policies. If the commissioner looks to the Guarantee Fund as he is statutorily entitled to do, he may assess member insurers to pay the outstanding claims of the Association and then, exercising his powers under Section 17:30A he can permit those members to surcharge their insureds. Preliminary calculations indicate that the amount of surcharge required to make up the entire \$64,400,000 deficit would be approximately .5 of 1 percent on each policy. The amount would be even less if, as we are led to believe, the fund has existing assets as a result of prior surcharges.

The doctors that Officer Bakke seeks to surcharge have been obediently paying into that Liability Guarantee Fund to assist distressed insurance companies during the past 14 years. Now that the state's own insurance company is distressed, we request that the Department use the statutory procedure which it does have, which provides for precisely this situation, and utilize the Guarantee Fund which is in place for this very purpose rather than seeking to double-surcharge innocent doctors who were in practice and to surcharge other doctors who were not in practice or even in the state while the Association was writing insurance.

In conclusion, the Plan proposed by the commissioner and revised by Officer Bakke is unfair, inequitable, and beyond the commissioner's statutory power. However, a lawful statutory procedure exists to address the need to assist the insolvent Association. We respectfully urge you to utilize this statutory solution. (signed) Herbert J. Stern.

MEDICARE CARRIERS IN TRANSITION

Pennsylvania Blue Shield has replaced Prudential as the Part B Carrier in New Jersey. A host of processing and policy problems were documented during January and February. On March 1, 1989, Mr. Lucci and Mr. Maressa met with representatives of Pennsylvania Blue Shield and HCFA at MSNJ headquarters. A corrective monitoring system was agreed upon and future meetings to evaluate progress have been scheduled. Physicians experiencing difficulty should document their problems and forward them to Mr. Lucci. He will direct them into corrective action at Pennsylvania Blue Shield.

FINANCIAL DISCLOSURE BECOMES LAW

Physicians directing patients for testing, diagnosis, treatment, drugs, or devices, provided by an entity in which the physician or an immediate family member has a significant financial interest (5 percent or \$5,000), must make disclosure of that fact to the patient. The disclosure must be posted in the office in a conspicuous place and must also be given to the patient as follows: "Public law in New Jersey mandates that a physician, chiropractor, or podiatrist inform his patients of any significant financial interest he may have in a health care service to which he refers patients. I wish to inform you that I have a financial interest in the following health care services to which I refer my patients. You may of course seek these services at the provider of your own choice. A listing of these alternative providers can be found in the classified section of the telephone directory under the appropriate heading."

PROFESSIONAL SERVICE AWARD

The Medical Society of New Jersey has acknowledged Dr. Sandy S. Milgraum's splendid, extraordinary efforts on behalf of a young patient with alopecia totalis. MSNJ awarded Dr. Milgraum the Professional Service Award to recognize his professional competence as evidenced by grateful patients. Dr. Milgraum provides a heartwarming example of a dedicated physician going that extra mile as a shining symbol of true professionalism. Here's to a job well done.

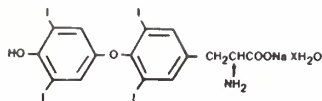
LEVOXINE®

(LEVOTHYROXINE SODIUM TABLETS, USP)

FOR ORAL ADMINISTRATION

DESCRIPTION:

Each LEVOXINE (Levothyroxine Sodium, USP) tablet contains synthetic crystalline levothyroxine sodium (L-thyroxine). L-thyroxine is the principal hormone secreted by the normal thyroid gland. Chemically, L-thyroxine is designated as L-thyroxine, O-(4-hydroxy-3, 5-diiodophenyl) - 3,5-diiodo-L-tyrosine monosodium salt, hydrate. The molecular formula is $C_{15}H_{10}I_2N_2NaO_4$ and the structural formula is:



CLINICAL PHARMACOLOGY:

The principal effect of thyroid hormones is to increase the metabolic rate of body tissues.

The thyroid hormones are also concerned with growth and development of tissues in the young.

The major thyroid hormones are L-thyroxine (T_4) and L-triiodothyronine (T_3). The amounts of T_4 and T_3 released from the normally functioning thyroid gland are regulated by the amount of thyrotropin (TSH) secreted from the anterior pituitary gland. T_4 is the major component of normal thyroid gland excretions and is therefore the primary determinant of normal thyroid functions. T_4 acts as a substrate for physiologic deiodination to T_3 in the peripheral tissues. The physiologic effects of thyroid hormones are mediated at the cellular level primarily by T_3 .

LEVOXINE (L-thyroxine) tablets taken orally provide T_4 which upon absorption can not be distinguished from T_4 that is secreted endogenously.

INDICATIONS AND USAGE:

LEVOXINE (L-thyroxine) tablets are indicated as replacement or supplemental therapy for diminished or absent thyroid function (e.g., cretinism, myxedema, nontoxic goiter or hypothyroidism generally, including the hypothyroid state in children, in pregnancy and in the elderly) resulting from functional deficiency, primary atrophy, from partial or complete absence of the gland or from the effects of surgery, radiation or antithyroid agents. Therapy must be maintained continuously to control the symptoms of hypothyroidism.

CONTRAINDICATIONS:

L-thyroxine therapy is contraindicated in thyrotoxicosis, acute myocardial infarction and uncorrected adrenal insufficiency.

WARNINGS:

Drugs with thyroid hormone activity, alone or together with other therapeutic agents, have been used for the treatment of obesity. In euthyroid patients, doses within the range of daily hormonal requirements are ineffective for weight reduction. Larger doses may produce serious or even life-threatening manifestations of toxicity, particularly when given in association with sympathomimetic amines such as those used for their anorectic effects.

PRECAUTIONS:

General — Caution must be exercised in the administration of this drug to patients with cardiovascular disease. Development of chest pains or other aggravation of the cardiovascular disease requires a reduction of dosage.

Information For The Patient — Patients on thyroid preparations and parents of children on thyroid therapy should be informed that:

1. Replacement therapy is to be taken essentially for life, with the exception of cases of transient hypothyroidism, usually associated with thyroiditis, and in those patients receiving a therapeutic trial of the drug.
2. They should immediately report during the course of therapy any signs or symptoms of thyroid hormone toxicity, e.g., chest pain, increased pulse rate, palpitations, excessive sweating, heat intolerance, nervousness, or any other unusual event.
3. In case of concomitant diabetes mellitus, the daily dosage of antidiabetic medication may need readjustment as thyroid hormone replacement is achieved. If thyroid medication is stopped, a downward readjustment of the dosage of insulin or oral hypoglycemic agent may be necessary to avoid hypoglycemia. At all times, close monitoring of urinary glucose levels is mandatory in such patients.
4. In case of concomitant oral anticoagulant therapy, the prothrombin time should be measured frequently to determine if the dosage of oral anticoagulants is to be readjusted.
5. Partial loss of hair may be experienced by children in the first few months of thyroid therapy, but this is usually a transient phenomenon and later recovery is usually the rule.

Laboratory Tests — The patient's response to thyroid replacement may be followed by laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels.

Drug Interactions — In patients with diabetes mellitus, addition of thyroid hormone therapy may cause an increase in the required dosage of insulin or oral hypoglycemic agents. Therefore, patients with diabetes mellitus should be observed closely for possible changes in antidiabetic drug dosage requirements.

Patients stabilized on oral anticoagulants who are found to require thyroid replacement therapy should be watched very closely when therapy is started. If a patient is truly hypothyroid, it is likely that a reduction in anticoagulant dosage will be required. No special precautions appear to be necessary when oral anticoagulant therapy is begun in a patient already stabilized on maintenance thyroid replacement therapy.

Cholestyramine binds both T_4 and T_3 in the intestine, thus impairing absorption of these thyroid hormones. In vitro studies indicate that the binding is not easily removed. Therefore, four to five hours should elapse between administration of cholestyramine and thyroid hormones.

Estrogens tend to increase serum thyroxine-binding globulin (TBG). In a patient with a non-functioning thyroid gland who is receiving thyroid replacement therapy, free thyroxine may be decreased when estrogens are started thus increasing thyroid requirements. However, if the patient's thyroid gland has sufficient function the decreased free thyroxine will result in a compensatory increase in thyroxine output by the thyroid. Therefore, patients without a functioning thyroid gland who are on thyroid replacement therapy may need to increase their thyroid dose if estrogens or estrogen containing oral contraceptives are given.

Drug/Laboratory Test Interactions — The following drugs or moieties are known to interfere with laboratory tests performed on patients taking thyroid hormone: androgens, corticosteroids, estrogens, oral contraceptives containing estrogens, iodine-containing preparations, and the numerous preparations containing salicylates.

1. Changes in TBG concentration should be taken into consideration in the interpretation of T_4 and T_3 values. In such cases, the unbound (free) hormone should be measured. Pregnancy, estrogens, and estrogen-containing oral contraceptives increase TBG concentrations. TBG may also be increased during infectious hepatitis. Decreases in TBG concentrations are observed in nephrosis, acromegaly, and after androgen or corticosteroid therapy. Familial hyper- or hypo-thyroxine-binding-globulinemias have been described. The incidence of TBG deficiency approximates 1 in 9000. The binding of thyroxine by thyroid-binding prealbumin (TBPA) is inhibited by salicylates.
2. Medical or dietary iodine interferes with all in vivo tests of radio-iodine uptake, producing low uptakes which may not be reflective of a true decrease in hormone synthesis.
3. The persistence of clinical and laboratory evidence of hypothyroidism in spite of adequate dosage replacement indicates either poor patient compliance, poor absorption, excessive fecal loss, or inactivity of the preparation. Intracellular resistance to thyroid hormone is quite rare.

Carcinogenesis, Mutagenesis, And Impairment Of Fertility

— A reportedly apparent association between prolonged thyroid therapy and breast cancer has not been confirmed and patients on thyroid for established indications should not discontinue therapy. No confirmatory long-term studies in animals have been performed to evaluate carcinogenic potential, mutagenicity, or impairment of fertility in either males or females.

Pregnancy — Category A — Thyroid hormones do not readily cross the placental barrier. The clinical experience to date does not indicate any adverse effect on fetuses when thyroid hormones are administered to pregnant women. On the basis of current knowledge, thyroid replacement therapy to hypothyroid women should not be discontinued during pregnancy.

Nursing Mothers — Minimal amounts of thyroid hormones are excreted in human milk. Thyroid is not associated with serious adverse reactions and does not have a known tumorigenic potential. However, caution should be exercised when thyroid is administered to a nursing woman.

Pediatric Use — Pregnant mothers provide little or no thyroid hormone to the fetus. The incidence of congenital hypothyroidism is relatively high (1:4,000) and the hypothyroid fetus would not derive any benefit from the small amounts of hormone crossing the placental barrier. Routine determinations of serum (T_4) and/or TSH is strongly advised in neonates in view of the deleterious effects of thyroid deficiency on growth and development.

Treatment should be initiated immediately upon diagnosis, and maintained for life, unless transient hypothyroidism is suspected, in which case, therapy may be interrupted for 2 to 8 weeks after the age of 3 years to reassess the condition. Cessation of therapy is justified in patients who have maintained a normal TSH during those 2 to 8 weeks.

ADVERSE REACTIONS:

Adverse reactions are due to overdosage and are those of induced hyperthyroidism.

OVERDOSAGE — Excessive dosage of thyroid medication may result in symptoms of hyperthyroidism. Since, however, its effects do not appear at once, the symptoms may not appear for one to three weeks after the dosage regimen is begun. The most common signs and symptoms of overdosage are weight loss, palpitation, nervousness, diarrhea or abdominal cramps, sweating, tachycardia, cardiac arrhythmias, angina pectoris, tremor, headache, insomnia, intolerance to heat and fever. If symptoms of overdosage appear, discontinue medication for several days and reinstitute treatment at a lower dosage level.

Laboratory tests such as serum T_4 , serum T_3 and the free thyroxine index will be elevated during the period of overdosage.

Complications as a result of the induced hypermetabolic state may include cardiac failure and death due to arrhythmia or failure.

TREATMENT OF OVERDOSAGE — Dosage should be reduced or therapy temporarily discontinued if signs and symptoms of overdosage appear. Treatment may be reinstituted at a lower dosage. In normal individuals, normal hypothalamic-pituitary-thyroid axis function is restored in 6 to 8 weeks after thyroid suppression.

Treatment of acute massive thyroid hormone overdosage is aimed at reducing gastrointestinal absorption of the drugs and counteracting central and peripheral effects, mainly those of increased sympathetic activity. Vomiting may be induced initially if further gastrointestinal absorption can reasonably be prevented and barring contraindications such as coma, convulsions, or loss of the gagging reflex. Treatment is symptomatic and supportive. Oxygen may be administered and ventilation maintained. Cardiac glycosides may be indicated if congestive heart failure develops. Measures to control fever, hypoglycemia, or fluid loss should be instituted if needed. Antiadrenergic agents, particularly propranolol, have been used advantageously in the treatment of increased sympathetic activity. Propranolol may be administered intravenously at a dosage of 1 to 3 mg over a 10 minute period orally, 80 to 160 mg/day, especially when no contraindication exist for its use.

DOSAGE AND ADMINISTRATION:

The goal of therapy should be the restoration of euthyroidism as judged by clinical response and confirmed by appropriate laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels. The age and general condition of the patient and the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage.

In otherwise healthy adults, the recommended initial dose is 25 to 100 mcg (0.025 to 0.1 mg) daily, while the predicted full maintenance dose of 100 to 200 mcg (0.1 to 0.2 mg) daily may be achieved in two to three weeks.

In the elderly patient with long standing disease, evidence of myxedema, or evidence of cardiovascular dysfunction, the initial dose may be as little as 12½ mcg (0.0125 mg) per day. Incremental increases of 25 mcg (0.025 mg) per day at 3 to 4 week intervals may be instituted depending on patient response. It is the physician's judgement of the severity of the disease and close observation of patient response which determine the rate and extent of dosage increase.

In infants and children there is a great urgency to achieve full thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult. The recommended daily replacement dosage of L-thyroxine in childhood is: 0-1 years: 5-6 mcg/kg; 1-5 years: 3-5 mcg/kg; 6-12 years: 4-5 mcg/kg of body weight daily.

DOSAGE FORMS AVAILABLE:

LEVOXINE (L-thyroxine) tablets are supplied as oval, color coded, potency marked tablets in eleven strengths: 12½ mcg (0.0125 mg)—maroon, 25 mcg (0.025 mg)—orange, 50 mcg (0.05 mg)—white, 75 mcg (0.075 mg)—purple, 100 mcg (0.1 mg)—yellow, 112 mcg (0.112 mg)—rose, 125 mcg (0.125 mg)—brown, 150 mcg (0.15 mg)—blue, 175 mcg (0.175 mg)—turquoise, 200 mcg (0.2 mg)—pink and 300 mcg (0.3 mg)—green, in bottles of 100, 1000, unit dose cartons of 100 (10 strips of 10 each), and 500 mcg injectable (See injectable package insert).

daniels
PHARMACEUTICALS, INC.

2517 25th Avenue North
St. Petersburg, Florida 33713-3999



CAPITOL COMMENTARY

NEW MEDICAL WASTE LAW

Physicians should be hearing shortly from the Departments of Environmental Protection (DEP) and Health about their responsibilities under the state's new medical waste law.

The law took effect on March 6, 1989, when Governor Thomas Kean signed the oft-amended S-2343/A-2853. The bill had undergone six major revisions as it passed back and forth between the Senate and Assembly.

Although the measure already is in effect, there is likely to be a considerable lag before all of its elements are in place.

When the statute is fully operational, physicians, dentists, veterinarians—as well as hospitals, laboratories, nursing homes, and other facilities—will be required to register with the DEP, assure that their medical waste is picked up by approved haulers, and fill out manifests. The haulers, in turn, are responsible for taking the waste to approved incinerators or landfills.

The law supercedes the confusing hodgepodge of municipal ordinances and county regulations which had governed medical waste disposal in various parts of the state.

For firsthand information, don't miss the Society's special seminar at its Annual Meeting this month. The program on environmental health will be held Sunday morning, at 8:30 A.M., April 30, 1989, at the Sheraton Meadowlands Hotel in East Rutherford. Dr. Stanley R. Lane, chairman of the Environmental Committee, will lead this conference.

DROP THE "M.D."?

New Jersey's health commissioner wouldn't have to be a physician if A-4142 becomes law. Sponsored by Assemblyman Walter Kavanaugh (R-Somerville) and Assemblywoman Joann Smith (R-Old Bridge), the bill would drop the physician requirement from current law, and specify instead that the commissioner be "qualified by training and experience in the field of public health." After removing the physician from the top job in the Department, A-4142 then would require at least one of the commissioner's deputies to be an M.D.

The bill revives an issue which has been discussed from time to time in previous legislative sessions, but with no resulting change. It is an idea which generally originates in the hospital community, exasperated with the Health Department's management of the DRG reimbursement system and eager to have policy set by a more sympathetic administrator.

GUBERNATORIAL CANDIDATES

Society leaders are meeting with a number of frontrunning candidates for governor in this year's election, informing them of our top issues and carefully weighing their answers. Topics under discussion include mandatory Medicare assignment, proposed malpractice insurance surcharge, Medicaid fees, tort reform, and legislation which would extend diagnosis, treatment, and prescription privileges to nonphysicians in New Jersey.

Adam Wilczek
uses a
four-letter word
talking
to doctors:

RISK

The number of malpractice claims filed against Exchange insureds has stabilized. We believe one reason for this trend is the success of our risk prevention program. It is aimed at identifying and minimizing those factors that lead to patient dissatisfaction and potential lawsuits. Risk prevention works.

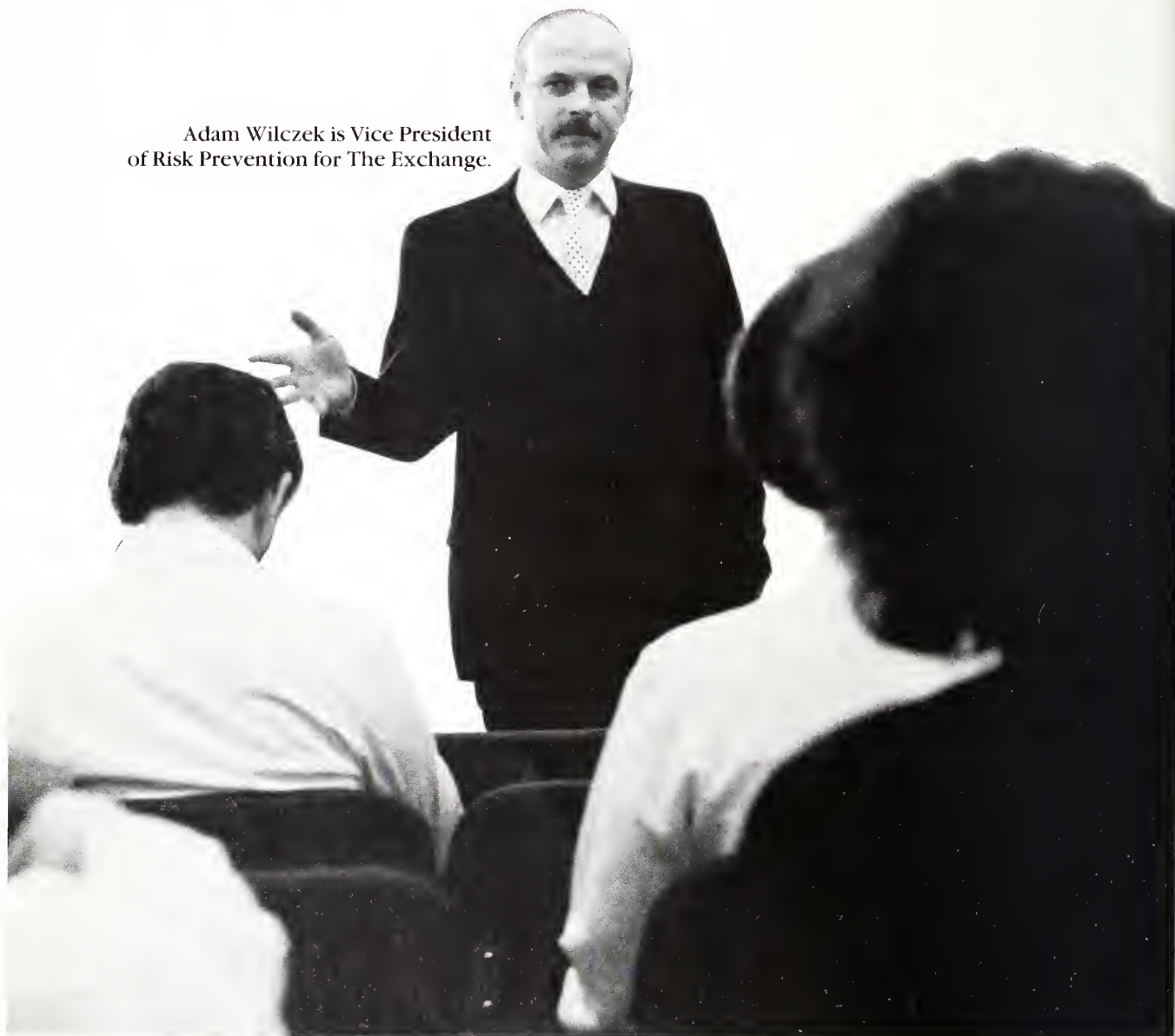
LEADERSHIP IN SUPPORT OF MEDICINE



**Medical Inter-Insurance
Exchange of New Jersey**

2 PRINCESS ROAD, LAWRENCEVILLE, NEW JERSEY 08648
PHONE: 1-800-257-6288

Adam Wilczek is Vice President
of Risk Prevention for The Exchange.





PROFESSIONAL LIABILITY

ELECTION OUTCOME FOR LIABILITY

In Alaska, voters overwhelmingly approved an initiative that compels the courts to award damages in proportion to fault. Previously, the "deep pockets" doctrine prevailed in the northernmost state. A defendant deemed responsible for the majority of fault was fully liable for all damages and a second defendant was liable for damages up to twice the share of fault. By a 70.4 percent margin, Alaskans endorsed the modified joint and several liability proposition. Raymond G. Schalow, executive director of Alaska State Medical Association, stated: "We have done a terrific job at the polls. The success of future tort reform now depends on who gets key judiciary and rules committee posts. In the past, these chairmanships have been held by attorneys with a different agenda from the rest of us." Schalow said the next step is to submit an omnibus reform bill to the Legislature, working with a strong, broad-based legislative coalition.

In Florida, a costly and hard-fought campaign to win approval for a constitutional amendment limiting noneconomic damages in all liability cases to \$100,000 failed by a vote of 57 percent to 43 percent. The Florida Committee for Liability Reform spent about \$6.9 million in support of the measure, while opponents, substantially bankrolled by Florida trial lawyers, spent \$5 million to \$7 million, arguing that it would "protect criminals and drunk drivers."

It was in California that what has been termed a "disastrous" initiative for insurers, including medical malpractice carriers, was endorsed by a narrow 51 percent margin. Proposition 103, 1 of 29 direct-to-the-voters issues on California's ballot, requires all liability insurers to roll back rates to levels 20 percent below those in effect in November 1987. Immediately, all four of the physician-owned professional liability insurers in the state filed suit with the California Supreme Court in San Francisco to stay implementation of the initiative, which became effective November 9th. A California insurance trade association and seven commercial companies also rushed to the courthouse with a similar suit, saying that they would lose \$10 million a day in premiums if the initiative were allowed to become effective. Within 24 hours, the Supreme Court issued a temporary restraining order indefinitely postponing implementation of the new measure. The issue is on hold. Observers speculate the court will send the initiative back to the Legislature where a compromise may be worked out. (*Medical Liability Monitor*, November 18, 1988, Volume 13, Number 10)

EMOTIONAL HARM FROM FETAL DEATH

Suffering is rarely limited to a single person. Parents, children, spouses, and siblings may suffer intense mental anguish when a loved one is physically injured. One of the classical issues in tort law is to set the rules governing who may reasonably seek compensation for this emotional harm. In some states, a person who has not suffered an antecedent physical injury is not permitted to sue regardless of the relationship to the party who did suffer physical harm. In all states, the universe of

potential plaintiffs is small, and is determined largely by the familial relationship and by examination of the party's propinquity to the alleged negligent event. In an interesting exploration of this problem, a North Carolina court has held that a woman may sue her obstetrician for the emotional harm caused by his alleged mismanagement of her pregnancy which ended in the death of a seven-month fetus.

The plaintiff, who suffered from hypertension, became pregnant at age 37. Her obstetrician was aware of her high blood pressure, but allegedly did not inform her of the risks it posed to the fetus.

At about seven months of pregnancy, the plaintiff began suffering severe abdominal pain. The pain to the patient continued intermittently for about two weeks, during which time the obstetrician conducted two nonstress tests and reassured the patient. A few days after the second test, fetal movements ceased and fetal death was diagnosed. The patient sued the obstetrician.

The plaintiff's claims for physical, mental, and emotional injuries were dismissed by the trial court and the plaintiff appealed. On appeal, the defendant-appellees argued that in North Carolina parents could not recover for the pain, suffering, or anguish caused by a child's injury or death. Reviewing that rule, the appellate court asserted that it was based on an assumption that in general such suffering was too remote and unforeseeable to justify a finding that the defendant's negligence caused it.

The court then decided that when a fetus dies inside the mother, her suffering is foreseeable. The court also decided that the abdominal pain to the mother associated with the fetal demise and the necessity of the patient undergoing surgical removal of a dead fetus were hardly remote events. Furthermore, they satisfied the requirement that there be for the patient a physical injury to support a claim for negligent infliction of emotional suffering.

This decision is no mere curio. We are in the midst of a revolution in prenatal diagnosis, the era of fetal surgery has arrived, and the challenge of managing high-risk pregnancies increases daily. This undoubtedly means that there will be an increase in iatrogenically-caused fetal death and a comparable increase in liability exposure. This decision also suggests that the potential liability will include both wrongful death actions on behalf of a fetus that died after reaching the point of viability and claims by parents for their anguish. (*Medical Liability Monitor*, November 18, 1988, Volume 13, Number 10)

COMMENTARY: FETAL DEATH

The Supreme Court of New Jersey held that parents may recover compensatory damages for their emotional distress and mental suffering for medical negligence which causes the stillbirth of their infant. The court reasoned "the legitimacy of such a claim brought by a family member, and the genuineness of the ensuing emotional distress all spring from and depend on the strength of family ties between the claimant and the victim."

In the same opinion, the Court reaffirmed existing law and held that an unborn fetus is not a "person" within the meaning of the Wrongful Death Act. The Court reasoned that the legislature never intended to create a derivative death action in favor of the survivors of a fetus never born alive. The Court maintained that the expanding and evolving common law in New Jersey adequately protects the parental interest involved in wrongful fetal death (111 N.J. 412, 1988).



PRESIDENT'S PAGE

PROFESSIONALISM REVISITED

Just before I delivered my inaugural address at the 222nd session of the Medical Society of New Jersey, I was asked what would be the theme of my year. Without hesitation, I said it was the reaffirmation of professionalism. It is time for doctors to say, "I am proud to be a physician, proud to be called to the healing arts as advocate and champion for my patients."

To the numerous groups I have addressed in this past year, my message has been the same: we are professionals, our patients come first. We must be unified and free to preserve the best health care system in the world. To those who follow us in the medical profession, we have the obligation to pass on the legacy of dedication, caring, ethical standards, and fraternal cooperation. We are not a public utility; we are not servants of the government.

In looking to the future, there is concern that the medical school applicant pool has decreased. Over the past 5 years, that pool has dropped to the level that existed 25 years ago (1.7 applicants for each position). Studies have been undertaken to determine why so few people are applying to medical school and why some of those who were accepted failed to matriculate. After cost and length of training, young people cited the discouragement they received from practicing physicians. They apparently are being told by doctors that as a profession, medicine no longer is worth the time, money, or effort.

How often have you heard a colleague complain that the "fun" has gone out of practice. It is understandable with the ever-increasing paperwork, government intrusion into medical decision making, threats of peer review organization sanctions, threats of anti-trust prosecution, and the continued specter of malpractice litigation. Physicians have not been fainthearted, now is not the time to yield to the temptation of jumping ship. Our profession is too valuable to abdicate our duty to the patients and to the future.

I attended a specialty society meeting where the national leadership was advocating mandated government control of reimbursement in order to assure an adequate share of the financial pie. One member even suggested that the time had come for a national health service. That session, perhaps, was the most discouraging day of my presidency. Driving home, I asked myself, "What's it all about? Have we missed the mark in the Medical Society of New Jersey? Have physicians changed so much that money is the prime concern? Have we been duped by the short-term goals? Have those who would control us found the "Judas coat" to lead the profession into enslavement?" Unfortunately, many of the members of that specialty organization were not aware of the actions of their national group.

At the 1989 National Leadership Conference, the American Medical Association had a session on physician reimbursement comparing the

systems in Britain, France, West Germany, and Canada. Those who have been advocating the Canadian system with its fee for service as a model for the United States have not looked at the problems which exist in Canada today. The doctors in Manitoba still are waiting for the fee increases which were promised in 1986. When the Ontario physicians reached an impasse with the government, they were told the negotiations were ended. There would be no further negotiations nor arbitration by government "fiat." "He who controls the gold makes the rules" certainly applies. We must keep a healthy skepticism when government makes promises. Consider what our government did with Medicare. Do we need to import a foreign health care system?

I believe the majority of physicians are proud of their profession and are concerned about the erosion of autonomy. Although most of us would like to be left alone to practice our profession, we cannot be oblivious to the forces of change all around us. We will not lose by default; the doctors in New Jersey are aware of the problems and are ready to meet the challenges. We have defeated mandatory assignment twice. Isn't it time we let our specialty societies know where we stand?

PRO QUALITY REVIEWS

Dear Doctor Formica: I am in receipt of your communication dated December 7, 1988, regarding peer review organization (PRO) quality reviews. I will start with my homemade proverb, "It is easier to criticize than synthesize."

The entire concept of PRO quality reviews is an insult to the profession. We spend four years in medical school, two to six years in postgraduate training, and have to comply with the continuing education program. I know of no other profession that is subjected to the harassment the PRO subjects us to.

My own concept concludes that this program is an endeavor to reduce the high cost of medical care. If that is so, a simpler method would be to reduce the costs of procedural medicine. It cannot be that echograms, nuclear cardiac studies, Holter monitors, and so forth are routine in cardiac analysis. Cognitive medicine should be encouraged, not substituted by procedural medicine. I would suggest there be a marked reduction in the costs for various procedures and a cooperative effort on the part of hospitals. The emergency room costs must be astronomical. I also note that nursing homes now are sponsoring portable x-rays, ECGs, and blood tests. Frequently, this gets out of hand as well.

In December 1988, I attended a two-and-a-half hour symposium sponsored by the American College of Cardiology in New York City. I was impressed with the lack of uniformity of opinion in the treatment of acute myocardial infarction. Five or six men on the panel varied in their answer to the question of how they would treat acute myocardial infarction.

I hope you do not mind my comments. ■ Emanuel M. Sickel, MD

MSNJ ANNUAL MEETING

I hope all members of MSNJ will attend our Annual Meeting, April 27 through April 30, 1989. This year there will be a symposium entitled, "Clinical Trials in HIV Infection: What To Do When the HIV Test Is Positive." The educational program, scheduled for April 27, 1989, at 1 P.M., is entitled, "Diagnosis and Management of Dissecting Aneurysm/Medical-Surgical Viewpoint." On Sunday, April 30, 1989, there will be a general session covering the subject of environmental health. I look forward to seeing you there.



BOOK REVIEWS

BLOOD TRANSFUSION IN CLINICAL MEDICINE

P.L. Mollison, C.P. Engelfriet, M. Contreras. Boston, MA, Blackwell Scientific Publications, 1988. As usual, this is an excellent text for any clinician involved with patients requiring multiple transfusions. There are 17 chapters ranging from the mechanics of blood withdrawal including exchange transfusions, plasmapheresis, plasma exchange, harvesting of lymphocytes and platelets, and the various anticoagulants for the collection of blood samples. There are individual chapters dedicated solely to the transfusion of red cells and the transfusion of platelets, leukocytes, and plasma components. There are five chapters dedicated to the red cell antigens and antibodies and their associated interactions including a separate chapter on the Rh blood group system, ABO, Lewis, and P blood groups as well as a separate chapter for just the other antigens, e.g. Kell system, Duffy system, Kidd system. A separate chapter is dedicated to the diagnostic laboratory detection between red cell antigens and antibodies with further analysis of red cell incompatibilities. The final chapters focus on the side effects of transfusions including the hemolytic disease in newborns and infectious agents transmitted by transfusions. This text, since its seventh edition, has included information regarding the human immunodeficiency virus (HIV) and its recognition that AIDS can be transmitted by transfusion. The text is well written and worth reading for all physicians who may come in contact with blood products or require the use of blood products, ranging from the immunologist using intravenous gammaglobulin to the hematologist, nephrologist, oncologist, or any other active clinician involved with transfusion of blood products. ■ Leonard Bielory, MD

IMMUNOLOGICAL DISEASES

Max Samter, MD. Boston, MA, Little Brown and Co., 1988. This text is the most complete book on immunological diseases and delightfully supplements another major text in allergy edited by Middleton. This is a fully updated fourth edition, presenting the latest developments in an ever-changing field of immunology. The text is sectioned into five parts on basic immunology, nonatopic immunological disorders, atopic diseases, allergic reaction patterns of the skin, and other diseases with immunological features.

In addition to reviewing basic immunology, the first part has chapters dedicated to the mucosal immune system and the immunology of reproduction. The second part is dedicated to non-IgE-mediated disorders and includes chapters on "allergic" reactions to drugs, adverse responses to immunizations, lymphoproliferative disorders, transplantation, and immunomodulatory agents. The third part is focused on the full scope of IgE-mediated disorders. The fourth part is dedicated to clinical conditions that affect the skin and includes chapters on bullous skin diseases, urticaria/angioedema, and mastocytosis. The fifth part is on "autoimmune" disorders such as the vasculitides, rheumatic fever, immunologic pulmonary and gastrointestinal disorders, immunohematology, immunoneurology, and immunologic endocrinopathies.

There are several new chapters on immunodeficiencies, lymphoproliferative disorders, myelomas, tumor immunology, and immunology in old age. This is a superb text; it is well referenced, easy to read, and clinically oriented. This text is a must for any physician interested in the field of immunology. ■ Leonard Bielory

LIABILITY. THE LEGAL REVOLUTION

Peter W. Huber. New York, NY, Basic Books, Inc., 1988. Mr. Huber holds a mechanical engineering doctorate from MIT and a law degree from Harvard. His goal is to convince the reader that the "law of accidents and personal injury" has been transformed rapidly by a band of legal scholars and economists into a system which he believes has stifled the growth and development of new products and technology.

Once a teacher, Mr. Huber believes in the old adage, "Tell them what you're going to tell them, tell them, and then tell them what you've told them." His tale is told by very cleverly written and often darkly humorous accounts of actual cases, many of them landmark judicial decisions in the developing law of products liability. The repetition of cases, no matter how ingenious their presentation, is frustrating for the reader who does not need so much convincing. By chapter 12 (out of 14 chapters), Mr. Huber finally advances a seemingly single idea that the present system of case by case adjudication by a jury (a tailor-made law of torts) is too costly and should be replaced by an exclusive system of broader no-fault first party payor compensation for those injured by accidents. Mr. Huber would permit questions of cause-and-effect to be determined by experts through some type of arbitration, and in the name of freedom, would abolish the right to a trial by jury to determine fault. Coupled with this no-fault system of compensation would be required warnings of the hazards of use of certain goods and services.

His provocative proposal deserves a fuller and more analytic presentation than is provided. Mr. Huber simply mentions that such a system would be akin to workers' compensation programs without providing the reader with any objective analysis of whether the workers' compensation system is cost effective or has provided reasonable assistance to accident victims at a cost fairly borne by employers. Perhaps a sequel to Mr. Huber's book is what really is needed. ■ James E. George, MD, JD

SURGERY ON FILE

Facts on File. New York, NY, 1988. This is the first volume of a unique attempt to place in the physician's possession a series of simple explanations and illustrations of procedures and operations which need to be explained to patients. This text, containing 175 pages, describes 50 topics. Pages are of a sturdy thick stock and are bound in a looseleaf notebook; they can be removed and copied. The copy is retained by the patient and the original is returned to the looseleaf notebook. In this day of "informed consent," this is an extremely valuable concept. The subheadings under each topic are straightforward, i.e. what is the procedure; why is it performed; what are the risks and benefits; how is the procedure done. The simple black-and-white illustrations are well done and easily understandable to the layman. The text is relatively jargon-free and should be effective for educating patients. The section on risks and benefits in each topic is a little tentative and far from complete; it requires expansion by the physician. An additional five-volume set is planned: obstetrics and gynecology, pediatrics, orthopaedics, trauma surgery, and ENT. Despite the modest shortcomings, I would recommend this volume to any practicing physician who wishes to keep his patients well informed as to operations or other procedures which they may have to undergo. ■ Benjamin F. Rush, MD

The Evolution of a Journal

GERALDINE HUTNER, MA

The Journal of the Medical Society of New Jersey has served the physicians of the state for 85 years. It has grown from a small, monthly report of Society news, to an established, award-winning medical journal.

In September 1904, the Medical Society of New Jersey published its first journal. Under the direction of Editor Richard Cole Newton, MD, *The Journal of the Medical Society of New Jersey (JMSNJ)* soon became known as an up-to-date, bright, monthly journal that proved helpful to members of the medical profession in their practical work and scientific knowledge. From its inception, *JMSNJ* was well received by the Society membership and by out-of-state colleagues.

The first American medical journal was established in 1880 when the American Medical Association began to issue a weekly journal so that members of the Association would be in "direct possession of valuable papers on almost every medical and scientific subject." By 1904, there were 12 state medical journals: Arkansas, California, Colorado, Illinois, Kansas, Kentucky, Michigan, Mississippi, Missouri, New York, Pennsylvania, and Wisconsin. New Jersey was next to join the growing list, and the first

issue of *JMSNJ* was cited in the *Journal of the American Medical Association* as "a very credible one, and promises to be of much value to the profession of the state."

THE EARLY YEARS

In July 1904, the Board of Trustees of MSNJ unanimously decided in favor of issuing a monthly journal under the direction of the Committee on Publication and Dr. Newton. *The Journal* was not to be a substitute for the annual Society transactions, but would be a scientific journal to enhance the knowledge of the 1,122 members of MSNJ. Society leaders felt the publication of a journal would advance the direction of scientific writing and allow for the more efficient dissemination of information throughout the state.

The format of the early issues of *JMSNJ* was simple: each issue opened with an address by an officer of the Society, followed by correspondence from members, news items such as hospital appointments, practice openings, weddings, and obituaries, reports from committees and councils, and letters from county society "reporters or secretaries" detailing the work of the component societies. Informa-

Ms. Hutner is executive editor of *NEW JERSEY MEDICINE*. Requests for reprints may be addressed to Ms. Hutner, *NJM*, Two Princess Road, Lawrenceville, NJ 08648.

tional articles on health statistics and weather conditions also were listed. Dr. Newton published a few scientific papers in each issue, but used *The Journal* largely as a vehicle for announcing and discussing Society news.

In 1906, the Committee on Publication nominated David C. English, MD, as the next editor. After a few months in his new position, Dr. English wrote the following editorial in the July 1907 issue: "We desire *The Journal* shall set forth the good work physicians are doing in private practice, in our hospitals, dispensaries, state institutions, and local organizations, as well as in shaping legislation for the protection of the lives and health of our citizens."

By 1908, Dr. English added a table of contents to the cover page of each issue, and expanded the articles section. He accepted photographs for publi-

cation, as well as speeches and seminars relating to the practice of medicine in New Jersey.

Over the next 15 years, Dr. English coaxed all members of the Society to contribute to *The Journal*; he believed this was the only way to highlight the Society's "good work" as well as to continually make the magazine better and "more helpful."

In the January 1921 issue, Dr. English reprinted an editorial from the *Kansas Medical Journal*; he noted that the comments summarized his thoughts:

A medical journal serves the purpose that a secular newspaper serves to the general public. The specialized medical journal serves the medical specialist in the same way that the technical scientific journal serves the technician in his handicraft. How best to serve the mixture in a medical society journal is a more difficult task than to meet the demands of the medical specialist journal.

It is taken for granted that the purpose of a state society journal is to help to establish, build up, and maintain the identity and individuality of the profession in a restricted area—the state. It is this medical journal way that the state is known professionally, outside of its bailiwick.

The worthiness of a medical society and of its exponent, the medical journal, is measured by the vigor of its own vitality, pushing ahead and making its influence felt at home and abroad, and in upbuilding self, that it may benefit the whole . . . Hence, each member of the society must contribute his might to fill up the family record completely. The editor and a small minority of the members of the family cannot conserve the interest of the whole medical family in its entirety.

If his medical society is not interesting or his medical journal is not readable, it is his duty to help make them worthwhile. The physician who does not take vital interest in the living medical issues of today soon becomes haphazard in his practice, more or less of a floater, a guesser, a dependent on authority, seemingly forgetful that he has the same machine to work with and on—the human body—as the other fellow.

During its first 20 years, the format of *The Journal* remained essentially the same. The typeface was simple, the layout functional. Advertisements were interspersed throughout *The Journal*, including the



Dr. Henry A. Davidson served as editor of *The Journal of the Medical Society of New Jersey* from 1941 until his death in 1973.

cover. Throughout this era, *JMSNJ* averaged 48 pages in length.

In 1924, Henry Reik, MD, became the new editor and served in that capacity until 1933. During his tenure, Dr. Reik worked to enhance the scientific content of *The Journal*, adding additional articles and formatting *The Journal*: scientific articles would have prominence, with Society news and information following. In January 1925, he wrote an editorial to the readers espousing his personal feelings about *The Journal*: "This is, really, your journal, that you have a direct personal interest in it You owe it to *The Journal* to present the best of your scientific work to the world through its columns; to publish your papers elsewhere is to deprive your own state medical society of that share of your renown that belongs to it." And five months later, Dr. Reik heralded in a new cover, hoping "you will like us better for the change and that you will be sufficiently attracted to induce closer investigation and more intimate study of our general makeup." The following month, Dr. Reik introduced four new columns in *JMSNJ*: professional ethics, professional economics, esthetics, and current events. In June 1926, Dr. Reik included additional material: lighthouse observations, lay mirror reflections, medical economics, ethics, and historic county reviews. Also, Dr. Reik again increased the number of scientific articles and reserved additional space for all the county reports available.

Throughout the late 1920s and the early 1930s, the size of *The Journal* increased tremendously with page counts averaging 90 pages, compared to approximately 30 pages in 1904. Advertisements now were "stacked," placed at the beginning or end of the journal.

Alfred E. Shipley, MD, was editor of *JMSNJ* for less than one year; in 1934, Frank Overton, MD, became the editor of *JMSNJ*.

In one of his first issues, Dr. Overton reviewed his feelings about *The Journal* which he published as an editorial:

Journals of a medical character are numerous and varied. Some are dedicated to the consideration of scientific subjects; others confine their attention to questions of research. Again, these scientific or research matters may concern special fields of medical endeavor; hence, the publications devoted entirely to certain specialties.

The Journal of the Medical Society of New Jersey has a specific purpose. The fundamental reason for the existence of such a periodical is service to members of its organization. Each member upon receiving



Dr. Frank Overton was editor of *The Journal of the Medical Society of New Jersey* from 1934 to 1941.

his copy expects, and has a right to find therein, articles and items which concern his daily life as a practitioner of medicine.

A state medical journal should be one of the media through which the physician can establish contact with, or derive inspiration from, his colleagues. He may receive encouragement by reading what they are doing. Items of professional interest coming from other parts of the state should give each member a broader outlook upon matters of a medical nature.

Dr. Overton believed *The Journal* had "triple" value: as a news pamphlet, as an educational textbook, and as a volume of records of the activities of the Society. Unfortunately, its use for the latter was limited because *JMSNJ* had no system to retrieve the information. After two years as editor, Dr. Overton felt *The Journal* needed a complete index, to reveal the scope and extent of the activities recorded and to make reports available for ready reference. His next change for *The Journal* came the following year when the entire table of contents, "the key which unlocks and reveals the treasures within the pages of *The Journal*," was placed on the front cover.

Because of the expense of printing and publishing a state medical journal, the editor needed to keep a constant eye and ear out to his readership. The editor needed to make sure that his changes, "his marks," on the journal were well received by the readers. Dr. Overton felt this pull and wrote an editorial in the January 1937 issue commenting on this situation:

We have about decided that the reason why doctors throughout the nation do not read their journals as thoroughly as they should is that the journals contain too much value, rather than too little. Let us analyze our own journal mathematically.

Each issue of the journal contains about 60 pages of solid reading.

Each page contains 800 words, making 48,000 words to be read every month.

It is a rapid reader who can read 200 words per minute. Therefore, he would have to read intensively 240 minutes or four hours in order to skim through each journal. Now really, is it right to expect a member to apply himself to that task, month after month?

The *New York Times* hired a literary girl to read one of its issues from end to end, and she was busy for two or three days at the task. How much of the newspaper does an average man read? Not much, and yet

the average commuter on the trains has an excellent grasp of the world's daily history.

We venture the opinion that the proportion of our medical journal which is read by the average member is far larger than the fraction of the *New York Times* that is read by the commuter.

BUILDING A TRADITION

In 1941, Henry A. Davidson, MD, became the editor of *JMSNJ*; except for a one-year hiatus when Rowland D. Goodman, 2nd, MD, was the editor from mid-1953 to mid-1954, Dr. Davidson remained at the helm until his death in 1973. Throughout the 1940s and 1950s, Dr. Davidson concentrated his efforts on maintaining the quality of *The Journal*. By the early 1950s, scientific articles had detailed research, abstracts, and references. There was a slight increase in the number of scientific articles published, but the bulk of *The Journal* remained county society reports, Society announcements, committee and council reports, obituaries, and miscellaneous medical news.

By 1952, advertisements were removed from the cover to make room for the complete table of contents. Each issue contained an average of eight original articles and a complete section of Society and state activities. Book reviews were added as well as public health news and an auxiliary column. Four years later, the entire layout of *JMSNJ* was modernized; the typestyle on the cover became more contemporary, as did the inside graphics; a higher grade of paper stock now was used.

"The dedication to serve the common good" was the stimulus for a major revamping of *The Journal* in January 1964. Dr. Davidson heralded in a new format which allowed for greater flexibility with editorial material. The contents were divided into three sections: editorials, original articles (averaging ten per issue), and state activities. Inside editorial pages



Dr. Howard Slobodien and Dr. Arthur Krosnick.

Table. *Journal* Editors.

1904-1906	Richard C. Newton, MD
1906-1923	David C. English, MD
1924-1933	Henry Reik, MD
1934-1934	Alfred E. Shipley, MD
1934-1941	Frank Overton, MD
1941-1953	Henry A. Davidson, MD
1953-1954	Rowland D. Goodman, 2nd, MD
1954-1973	Henry A. Davidson, MD
1973-1988	Arthur Krosnick, MD
1988-	Howard D. Slobodien, MD

were redesigned for readability and flow. With an increase in advertising revenue, color was added to the covers. In 1964, a color photograph of the headquarters building, with an overlay of the table of contents, made for a striking cover. During the 1960s, *JMSNJ* averaged 64 pages in length.

THE MODERN JOURNAL

Over the next 20 years, *JMSNJ* would undergo a variety of design changes, from cover concept to name. In the late 1960s, the table of contents and the Society seal were used on every color cover. In 1975, Arthur Krosnick, MD, took over the editorship and ushered in the modern era for *JMSNJ*. Beginning in 1976, the table of contents was moved inside the journal, and an illustration or photograph became the cover. With the graphic improvements, the audience for *The Journal* increased, as did advertising. Throughout the 1970s and 1980s, the journal staff redesigned the layout for ease of reading, using modern graphic techniques and typesyles.

During the 1970s, there was an explosion in the publishing field and *JMSNJ* competed for the physician's "reading" time. Dr. Krosnick wrote the following editorial in 1975:

JMSNJ serves several functions. It is clearly an educational organ, which permits amplification of one's clinical knowledge by a review of scientific papers, case reports, and special articles, especially if one compounds his store of facts by a review of selections from the bibliographies.

The Journal is also an informational tool, providing calendars of current local, state, and regional meetings, and direct communication from federal and state government. Announcements and obituaries are obviously of interest to New Jersey physicians as well as news about the College of Medicine and Dentistry of New Jersey. Readers always have an opportunity to be heard through letters to the editor. In the past, editorials have been devoted to points of interest to New Jersey physicians, including social issues. Guest editorials have been published from time to time.

It is our plan to keep *JMSNJ* responsive to the wishes and needs of New Jersey practitioners. . . . It is our aim to make *JMSNJ* a regular part of your reading material.

As editor, Dr. Krosnick instituted major changes in *The Journal*, from design to copy. He maintained the purpose of *JMSNJ*, first and foremost, was the

publication of scientific information through articles, case reports, state of the art reviews, opinions, and commentaries. As he wrote in May 1985, "Our goal has been to meet the informational and educational needs of New Jersey physicians, to present pertinent and current facts about governmental, social, and economic issues, and to serve as the 'house organ' of MSNJ."

With an increase of material presented to the medical community of New Jersey, the journal staff realized the need to make its state publication more appealing—so that the physician would want to read this monthly journal with greater interest. In 1985, *The Journal* changed its name to the present title, *NEW JERSEY MEDICINE (NJM)*. At the same time, the cover and inside layout were redesigned. Headings and logos were added to give each item its own identity and flavor. Over the next few years, additional material was added: professional liability commentary, physician legal bulletin, public affairs update, continuing medical education, health department updates, and a membership newsletter.

As a direct result of these efforts, *NJM* won numerous honors in the National Medical Journalism Competition, including first place in 1988.

THE FUTURE

In 1983, Dr. Krosnick wrote, "*The Journal* has remained the mouthpiece of the State Society, but its editors have functioned with independence and honesty. While the character of *The Journal* has changed very little, its style has varied with the times, reflected advances in medicine and science, changes in socioeconomic and legislative circumstances, and the needs of the members of the Society."

And the improvements continue. With this issue of *NJM*, a totally new look is presented. The typeface is enlarged, with a cleaner, bolder style. The cover has been redone, and more tables and photographs have been added. Also, additional members to our editorial board and new columns to our pages have been added. Under the leadership of editor-in-chief Howard D. Slobodien, MD, stricter guidelines for our scientific articles have been instituted, and all material is peer reviewed by at least two members of the Editorial Board.

The first issue of *The Journal* was read by 1,000 physicians. The 1989 issues are read by over 11,000 practitioners.

Design changes, though, are only skin deep. The staff of *NJM* hopes you like what you see. More importantly, the staff hopes you like what you read. *NJM* is here for you, for the health of your state, and the state of your health. ■

DEBTS COLLECTED

*by PROFESSIONALS
for PROFESSIONALS*

Deal directly with the Law offices of

SOL ROSENBERG P.A.

366 Clifton Ave.

P.O. Box 1325

Clifton, N.J. 07105

INQUIRIES INVITED

Phone (201) 340-2800

Fax (201) 340-2807

*35 Years experience
in medical collections*

References upon request.

WHERE IS YOUR PRACTICE GOING THIS YEAR?



WE CAN HELP BRING THEM BACK AND BUILD YOUR PRACTICE...

by designing a marketing plan and
carrying it out for you.

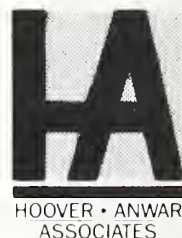
We work with all specialties.

**Call NOW for FREE Information
215-649-8770**

Rebecca Anwar, Ph.D.

Hoover Anwar Associates
Medical Marketing Services

First Pennsylvania Bank Building
Seven East Lancaster Avenue
Ardmore, PA 19003



PHYSICIANS KNOW HOW IMPORTANT QUALITY HEALTH CARE INSURANCE IS...

**THAT'S WHY MORE N.J. PHYSICIANS CHOOSE
MSNJ GROUP HEALTH CARE PLANS THAN
ALL OTHER POLICIES COMBINED.**



MSNJ GROUP

**BLUE CROSS/BLUE SHIELD
AND MAJOR MEDICAL INSURANCE**

DENTAL INSURANCE

LONG-TERM CARE INSURANCE

For more information, call (609) 924-8700

DONALD F. SMITH & ASSOCIATES

D&C Results Improved by Hysteroscopy

HERBERT A. GOLDFARB, MD

A review of the records of 287 women examined hysteroscopically prior to dilatation and curettage (D&C) and a review of the international literature on hysteroscopy indicate that there is significant evidence to support the routine use of hysteroscopy as an adjunct to D&C.

Since the early 1970s, hysteroscopy has been available to physicians as a diagnostic and therapeutic tool. However, the use of hysteroscopy has not become widespread.¹ This review is an attempt to determine the value of hysteroscopy as an adjunct to dilatation and curettage (D&C) for select indications based on clinical experience.

D&C, the most frequently performed procedure in gynecology, is the choice for diagnosis and treatment of abnormal uterine bleeding (AUB) and its causal conditions; other conditions diagnosed with D&C are endometrial polyps, submucosal leiomyomas, adenomatous hyperplasia, and endometrial carcinoma.

Despite its popularity, the efficacy of D&C has

Dr. Goldfarb is assistant clinical professor, UMDNJ-New Jersey Medical School, and is affiliated with the Department of Obstetrics-Gynecology, Montclair Community Hospital. Requests for reprints may be addressed to Dr. Goldfarb, 29 The Crescent, Montclair, NJ 07042.

been questioned.²⁻⁶ In a retrospective study by MacKenzie and Bibby, significant endometrial lesions were missed in 34 of 160 women who underwent a D&C followed by hysterectomy.² Routine D&Cs may be incomplete, as supported by the findings of Stock and Kanbour;³ their study of patients who underwent hysterectomy following D&C demonstrated that less than 50 percent of the uterus had been curetted in 60 percent of the patients and less than 25 percent had been curetted in an additional 16 percent of the patients.

The shortcomings of D&C led Mecaglia et al. to conclude "the usefulness of dilatation and curettage in about half of the AUB patients over 45 should be questioned seriously."⁷

Because D&C is a blind procedure, direct visualization of the uterine cavity should improve both its efficacy and completeness. The hysteroscope is the tool that allows such visualization.⁸ Hysteroscopy has been shown to be of considerable value

in locating endometrial polyps, submucosal leiomyomas, uterine anomalies, and endometrial cancers often undetected at D&C.

PROCEDURE

Between May 1981 and December 1985, 287 patients with metrorrhagia, recurrent menorrhagia, or a combination of both were seen for D&C. These patients ranged in age from 19 to 83 years. At the time of surgery, each patient also underwent hysteroscopy.

Hysteroscopy was performed as an outpatient procedure in a hospital using a Storz endoscope with operating sheath and Hyskon 32 percent dextran 70 as a distending medium. Patients were given general anesthesia or intravenous narcosis. Minimal cervical dilatation was used to reduce fluid leakage. A Hyskon pump (RSP Laboratories) was used for infusion. Following hysteroscopy, fractional curettage was performed using a Heaney curette followed by a sharp Randall curette.

In all cases, the endometrium was sampled. If endometrial polyps, pedunculated myomas, or synechia were noted, therapeutic curettage, polypectomy, or myomectomy was performed, followed by a repeated hysteroscopy. If pathology still was

visible, the specific procedure was performed again, followed by a third hysteroscopy. This series of procedures was repeated until no evidence of pathology was visible.

RESULTS

Of the 287 patients evaluated, 96 patients (33.45 percent) had hysteroscopic findings that indicated the need for curettage or other surgical correction. Six additional patients (2.09 percent) were found to have subserosal leiomyomas, which were not diagnosed hysteroscopically. These patients were treated expectantly. No visible pathology was found in the remaining 185 patients (64.46 percent) and no further testing was recommended.

In the 96 patients with visible pathology, 70 patients were found to have endometrial polyps during hysteroscopy. Another 26 patients were found to have intramural and submucosal leiomyomas (Table 1).

Of the 96 patients, 81 patients required therapeutic curettage. Sixty patients (74.07 percent) required repeated curettage for complete elimination of the intrauterine pathology, although initial hysteroscopic visualization of pathology clearly indicated its position in the uterine cavity (Table 2). Age breakdown of patients who underwent D&C is shown in Table 3.

Fifteen of the 96 patients with visible pathology were not treatable by curettage. One patient underwent hysterectomy followed by radiotherapy after adenocarcinoma of the endometrium was diagnosed via hysteroscopy. Large fibroids were seen in 14 patients, 10 patients underwent myomectomy, and 4 patients underwent hysterectomy.

There were two complications out of the 286 procedures. Two patients suffered photosensitivity as a result of allergic reactions to the Hyskon; both made complete and uneventful recoveries.

DISCUSSION

Although the hysteroscope generally had been available for 15 years, it has not achieved a wide range of use. Since hysteroscopy allows the uterine cavity to be visualized, it is a valuable complement to the current blind diagnostic technique of D&C. More importantly, hysteroscopy is a critical aid in identifying and removing abnormal tissue that may go undetected with other diagnostic methods. It also makes it possible to perform certain surgical procedures: polypectomy, myomectomy, lysis of intrauterine synechiae, and resection of intrauterine septum while maintaining total visual control.

Reports in the literature show the importance of hysteroscopy for gynecological conditions and its general acceptance as a routine office procedure in

Table 1. Pathology identified with the use of hysteroscopy.

	Patients	Percentage
Endometrial polyps	70	66.03
Intramural and submucosal leiomyomas	26	24.52
Large fibroids	10	9.43
Total	106	100.0

Table 2. Summary of curettage attempts needed to clear uterine cavity.

	Patients	Percentage
Single curettage	21	25.9
Multiple curettages	60	74.1
Total	81	100.0

Table 3. Age distribution of patients admitted for curettage with ancillary hysteroscopy.

Ages	Patients
19-29	51
29-39	126
39-49	80
>49	30
Total	287

many parts of the world. Studies from Japan, the Soviet Union, New Zealand, and Italy discuss the contribution of hysteroscopy to improved diagnostic and treatment results.¹¹⁻¹⁷ Hysteroscopy's importance in a wide range of applications is repeatedly indicated, from its use in the management of high-risk malignancies to recovery of lost IUDs, infertility diagnosis, and in the diagnosis of endometrial neoplasia leading to AUB.¹⁸⁻²⁸

Hysteroscopy offered these 287 women significant benefits. Without hysteroscopy, each patient would have been subjected to at least one curettage in addition to endometrial sampling. Of the 287 patients, 185 were spared this procedure because hysteroscopy uncovered no visible pathology.

In addition, the 60 patients for whom repeated therapeutic curettage was performed were able to receive definitive treatment in one session. Without hysteroscopy, these patients would have had to re-

turn for one or more repeats of the entire curettage procedure, while continuing to suffer from their symptoms. The combination of curettage with hysteroscopy also ensured that the entire uterine cavity was cleaned, avoiding the pitfall of an incomplete curettage as seen by Stock and Kanbour.³

CONCLUSION

Clinical findings attest to the value of hysteroscopy as an adjunct to diagnostic and therapeutic D&C. For certain conditions, hysteroscopy is the superior diagnostic tool. In light of the wide range of therapeutic procedures possible through the hysteroscope and the international documentation indicating its value, hysteroscopy routinely should be used for diagnosis. It will reduce significantly the number of curettages, patient risk, and health care costs, improve the accuracy of the D&C, and greatly improve outcomes. ■

REFERENCES

1. Lubke F: Principles and practice of hysteroscopy. *Acta Eur Fertil* 17:413-416, 1986.
2. MacKenzie IZ, Bibby JG: Critical assessment of dilatation and curettage of 1,029 women. *Lancet* 2:566-568, 1978.
3. Stock RJ, Kanbour A: Prehysterectomy curettage. *Obstet Gynecol* 45:537-541, 1975.
4. Goldrath MH, Sherman AI: Office hysteroscopy and suction curettage: Can we eliminate the hospital diagnostic dilatation and curettage? *Am J Obstet Gynecol* 152:220-229, 1985.
5. Danero S, Ricci MG, La Rosa R, et al.: Critical review of dilatation and curettage in the diagnosis of malignant pathology of the endometrium. *Eur J Gynaecol Oncol* 7:162-165, 1986.
6. Valle RF: Hysteroscopic evaluation of patients with abnormal uterine bleeding. *Surg Gynecol Obstet* 153:521-526, 1981.
7. Mecaglia L, Perino A, Hamou J: Hysteroscopy in perimenopausal and postmenopausal women with abnormal uterine bleeding. *J Reprod Med* 32:577-582, 1987.
8. Neuwirth RS: *Hysteroscopy*. Philadelphia, PA, WB Saunders Company, 1985.
9. Taylor RJ, Hamou JE: Hysteroscopy. *J Reprod Med* 28:359-389, 1983.
10. Valle RF: Hysteroscopy for gynecologic diagnosis. *Clin Obstet Gynecol* 26:253-276, 1983.
11. Lin BL, Miyamoto N, Tomomatsu M, et al.: The development of a new flexible hysteroscope and its clinical application. *Nippon Sanka Fujinka Gakkai Zasshi* 39:649-654, 1987.
12. Takashima E: Usefulness of hysteroscopy for detection of cancer in the endocervical canal. *Nippon Sanka Fujinka Gakkai Zasshi* 37:2401-2409, 1985.
13. Sudoma IA, Iatskovskaia NL, Kokhanovich EV: Value of hysteroscopy in the diagnosis of uterine myoma. *Akush Ginekolog* 2:27-28, 1986.
14. Duncan GR, Weerasinghe DS: The diagnostic possibilities of a modified hysteroscopic technique. *NZ Med J* 98:101-103, 1985.
15. Noci I, Tantini C, Dubini V, et al.: Hysteroscopy and endometrial biopsy. *Acta Eur Fertil* 18:59-60, 1987.
16. Neis KJ, Hepp H: The accuracy of combined hysteroscopy and line biopsy under ambulatory conditions. *Acta Eur Fertil* 17:445-448, 1986.
17. Fedele L, Vercellini P, Ricciardiello O, Arcaini L, Candiani GB: Second-look hysteroscopy after conservative surgery of the uterus. *Acta Eur Fertil* 17:341-343, 1986.
18. Raju KS, Taylor RW: Routine hysteroscopy for patients with a high risk of uterine malignancy. *Br J Obstet Gynaecol* 93:1259-1261, 1986.
19. Burmucic R, Mayer HO, Kometter R: Diagnosis and treatment of an occult intrauterine device. *Wien Med Wochenschr* 137:104-107, 1987.
20. Mittal S, Gupta I, Lata P, et al.: Management of translocated and incarcerated intrauterine contraceptive devices. *Aust NZ J Obstet Gynaecol* 26:232-234, 1986.
21. Taylor PJ, Leader A, George RE, Fick GH: Correlations between laparoscopic and hysteroscopic findings in 497 women with otherwise unexplained infertility. *J Reprod Med* 29:137-140, 1984.
22. Dargent D, Scasso JC: Hysteroscopy-curettage under local anesthesia in the exploration of abnormal uterine bleeding. *Rev Fr Gynecol Obstet* 79:293-296, 1984.
23. DeCherney A, Polan ML: Hysteroscopic management of intrauterine lesions and intractable uterine bleeding. *Obstet Gynecol* 61:392-397, 1983.
24. Choo YC, Mak KC, Hsu C, et al.: Postmenopausal uterine bleeding of nonorganic cause. *Obstet Gynecol* 66:225-228, 1985.
25. Smith CB: Dysfunctional uterine bleeding. *Am Fam Physician* 36:161-168, 1987.
26. Cronje HS: Diagnostic hysteroscopy after postmenopausal uterine bleeding. *S Afr Med J* 66:773-774, 1984.
27. Dexeus S, Labastida R, Marques L: Hysteroscopy in daily gynaecologic practice. *Acta Eur Fertil* 17:423-425, 1986.
28. Luo QD: Evaluation of hysteroscopy in the diagnosis of abnormal uterine bleeding. *Chung Hua Fu Chan Ko Tsa Chih* 21:152-154, 1986.

MARCH 1989
VOL 29 NO 3

THE JOURNAL OF MEDICAL CONSULTATION

Consultant



Last month 125,000 of your colleagues learned all this. It took them just 35 minutes

HYPERLIPOPROTEINEMIA: A TIME-SAVING REVIEW

- Gouging Patients' Risks and Instituting Dietary Control
- When and How to Use Cholesterol-Lowering Drugs
- The Role of Lipoproteins in Transporting Cholesterol

CHRONIC FATIGUE SYNDROME

Current Recommendations for Diagnosis and Management

HODGKIN'S DISEASE AND NON-HODGKIN'S LYMPHOMA

Pitfalls and Controversies in Diagnosis and Treatment

HMO UPDATE

Where Are They Headed?

DRG 'CREEP'

Pitfalls and Sanctions To Avoid



REGULAR MONTHLY DEPARTMENTS

- Reader Consultations
- Practical Pointers
- Photoclinic
- Cost Containment Issues

The age old challenge. How do you keep down the time it takes to keep up to date?

The answer is simple.

You do it with **CONSULTANT**.

CONSULTANT SOLVES THE PROBLEM OF INFORMATION VS. TIME. Period. The key: **CONSULTANT's** unique editorial format—**EVERYTHING YOU NEED TO KNOW, FROM CLINICAL ADVICE TO COST CONTAINMENT**, in a quick, readable, style.

And since **CONSULTANT's** contributors are physician authors, **SOME OF THE BRIGHTEST NAMES IN**

MEDICINE ARE AVAILABLE FOR FREE CONSULTATION.

Such as Henry Black, Yale University School of Medicine; Faith Fitzgerald, University of California School of Medicine at Davis; Dale Murphy, Akron (Ohio) City Hospital; Frank Myers, College of Osteopathic Medicine, Athens, Ohio; David Nash, University of Pennsylvania; Robert Rakel, Baylor College of Medicine; Edward Shahady, University of North Carolina School of Medicine.

THIS MONTH, PICK UP THE INFORMATION YOU NEED. PICK UP SOME TIME GETTING IT. PICK UP CONSULTANT. CONSULTANT. Value—cover to cover.

Consultant

The Journal of Respiratory Diseases • The Journal of Critical Illness • The Journal of Musculoskeletal Medicine
Ciggott Publishing Co. • 55 Holly Hill Lane • Box 4010 • Greenwich, CT 06830 • (203) 661-0600 • (212) 993-0440

Pancreatitis of Pancreas Divisum

M. NURI KALKAY, MD
ARNOLD DERMAN, MD

Pancreas divisum is a frequently encountered congenital anatomic variant of the pancreatic ductal system. Its presence alone rarely causes pancreatitis on the basis of "functional obstruction" at the minor papilla. Endoscopic and surgical interventions, to relieve hypothetical obstruction at the minor papilla, may not be necessary at all.

Pancreas divisum (PD) is the most frequently encountered congenital anatomic variant of the pancreatic ductal system.¹⁻³ Its incidence in postmortem studies ranges between 4.7 to 14 percent,^{4,5} while in endoscopic retrograde cholangiopancreatography (ERCP) studies, its incidence is around 5 percent.^{1-3,6} PD is the result of the nonunion of the dorsal and ventral pancreatic buds in such a way that most of the pancreatic parenchyma is drained through the dorsal pancreatic duct (DPD), through the relatively small duct of Santorini, and through the minor papilla (MiP), while the ventral duct drains only the uncinate process and part of the head of the pancreas via the major papilla (MaP) (papilla of Vater) (Figures 1 and 2). Consequently,

the orifice of the MiP may be inadequate to allow free flow of pancreatic secretions from the major portion of the pancreas. This is the basis of obstruction to flow and pancreatitis hypothesis in cases of pancreas divisum.⁷⁻¹⁰ This hypothesis initially created much enthusiasm among its supporters and caused widespread efforts to cannulate MiP and to intervene surgically or endoscopically for the purpose of diagnosis and/or treatment of PD.^{6,11-15}

We present a typical case of PD pancreatitis, review the current medical literature on the subject, discuss the methods for successful cannulation of generally very difficult minor papilla, and re-evaluate the validity of obstruction to flow and pancreatitis hypothesis in the pathogenesis of PD pancreatitis.

CASE REPORT

A 36-year-old black female was admitted to the hospital on October 10, 1987, because of severe, episodic upper abdominal pains, nausea, and bile-

Dr. Kalkay is affiliated with the Department of Medicine and Dr. Derman is affiliated with the Department of Radiology, Bayshore Community Hospital, Holmdel. Requests for reprints may be addressed to Dr. Kalkay, Bayshore Community Hospital, 727 North Beers Street, Holmdel, NJ 07733.



Figure 1. Schematic representation of normal pancreatic ductal system.



Figure 2. Schematic representation of PD anomaly.

containing vomiting. Abdominal pain occurred mostly postprandially over a three-month period and showed no definite radiation. There were no

associated systemic manifestations; she had no history of alcohol consumption, drug abuse, or previous abdominal surgery. She was not on any medications.

Vital signs were stable; she was afebrile. Physical examination was within normal limits except for the fact that she had obvious epigastric tenderness to deep palpation.

Pertinent laboratory findings showed an elevated serum amylase level ranging between 770 to 232 U/L on multiple determinations, and mild leukocytosis,^{4,12} with a shift to the left. Blood chemistry, serum transaminases, serum calcium, blood sugar, lipid profile, T₃, and T₄ were normal. Ultrasound of the gallbladder, CT scan of the abdomen, and an upper gastrointestinal series failed to reveal any abnormalities.

ERCP showed normal biliary ductal system and gallbladder. In spite of multiple attempts, a complete pancreatogram could not be obtained via the ampulla of Vater except for small ductal opacifications in the head of the pancreas (Figure 3). Dorsal pancreatography could only be obtained following a successful cannulation of MiP, which showed minimal dorsal pancreatitis, and slight dilation of the pancreatic ductal system (Figure 4).

The patient responded to conservative medical treatment in the form of gastric and pancreatic rest, initially with nasogastric tube suctioning and systemic H₂-blockers, and later on a low-fat diet and pancreatic enzyme supplements. She was discharged three weeks later with a normal serum amylase and in a pain-free state. Since her discharge, she has been doing well with the same regimen, and her serum amylase levels repeatedly remain normal.

CANNULATION OF THE MINOR PAPILLA

The minor (accessory) papilla is located 2 to 3 cm above (cephalad) and slightly to the left of the major papilla. It is 1 to 2 mm in diameter and shows no definite papillary appearance. Quite often, it is impossible to recognize the MiP without giving intravenous secretin and observing the discharge of pancreatic secretions from it.

Even though the long-scope route is much more uncomfortable for the patient, it is the best method of approach to the MiP because the long-scope position prevents frequent slipping back into the stomach. As stated before, the MiP is closer to the duodenal bulb; therefore, scope-straightening maneuvers to achieve short-scope position frequently result in a slippage back into the stomach.

First, the major papilla (Vater) is located (as in a routine ERCP) with the usual maneuvers. The scope then is pushed forward a little more until the MiP is located or its possible location visualized. At this stage, it is necessary to give intravenous secretin (1U/Kg IV push) to pinpoint the minor papilla and its opening. In a few minutes, when pancreatic

secretions begin to flow, a fine, soft-tip wire guide (0.46 mm in diameter), with the help of a 3-French straight tip angiographic catheter, is passed through the biopsy channel of the scope. Under the visual and fluoroscopic control, the MiP is cannulated with the wire guide, and it is pushed towards the body and the tail of the pancreas. Afterwards, the angiographic catheter is advanced over the wire guide into the DPD. Then, while the catheter is kept steady in the dorsal duct, the wire guide is withdrawn carefully, contrast is injected through the catheter under fluoroscopic control, and the necessary films obtained.

It is our experience that the wire guide cannulating technique described by McCarthy¹⁶ is far superior to the other cannulating techniques using metal tip or tapered tip catheters.^{6,17,18}

DISCUSSION

The diagnosis of PD could only be made by cannulating the MiP and visualizing the DPD. Therefore, in some ERCP cases where the biliary ducts are visualized easily, but pancreatography fails and cannulation of the MiP is not done, it is inevitable that the PD anomaly will be missed.¹⁹

The role of PD in the etiopathogenesis of pancreatitis remains controversial.^{1,3,10,19,20} The "obstruction to flow hypothesis,"^{8,10} in spite of initial enthusiasm, has lost its appeal,^{1,3} because it fails to answer many critical and fundamental questions or statements.

If the obstructive theory of PD is correct, then all cases of PD anomaly should develop pancreatitis and should develop it at an early age. However, medical literature does not support this idea. While the incidence of PD anomaly in postmortem studies ranges between 7.4 to 14 percent,^{4,5} it is about 5 percent in ERCP studies.^{1,3,6} PD is only a very rare cause of pancreatitis,^{2,19,20} and the average age of PD pancreatitis is approximately 33 years.¹⁹

The incidence of pancreatitis among patients, with or without PD anomaly, has not been different.^{1,3} PD anomaly is diagnosed with the same frequency in cases of acute pancreatitis and in chronic pancreatitis (6.9 percent), and in a control population (cases without pancreatitis) (5.7 percent).^{1,3,6} Furthermore, there is no increased incidence of PD anomaly among patients with idiopathic pancreatitis (pancreatitis with no identifiable cause).^{1,3}

Pancreatic ducts dilate easily after any significant obstruction; therefore, the absence of poststenotic dilatation in cases of PD pancreatitis^{1,2} strongly could be considered as evidence contrary to the obstructive theory.^{1,2}

Examinations of surgical specimens or postmortem specimens of pancreas divisum pancreatitis

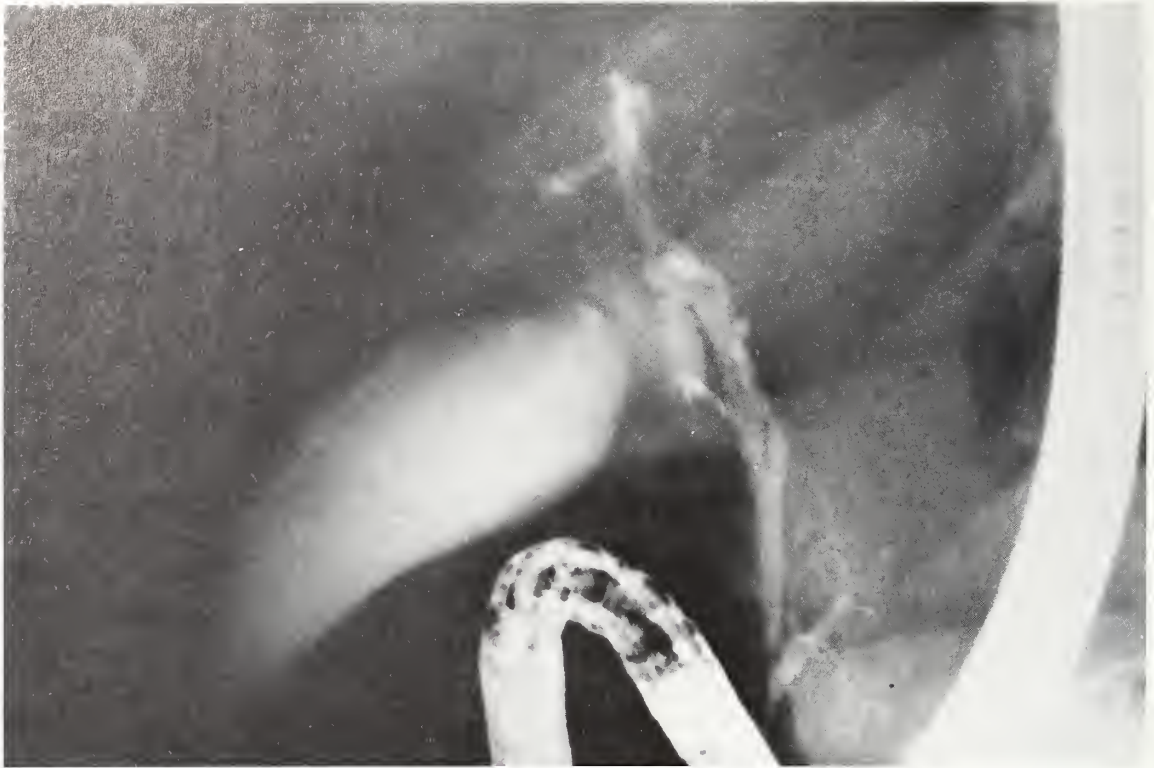


Figure 3. Cannulation of the major papilla and simultaneous visualization of the normal biliary ductal system and a small portion of the pancreatic head and uncinate process, without visualization of any other pancreatic ductal system.



Figure 4. Cannulation of the minor papilla (MiP) using the long-scope position and visualization of the dorsal pancreatic duct. Note slight caliber changes in the dorsal pancreatic duct.

have demonstrated a segmental pancreatitis, localized mainly to the dorsal pancreas.¹⁹ Since DPD, in cases of PD, drains via the MiP, could this finding be considered as evidence of the obstructive theory?^{2,19} Could it be simply because most of the pancreatic mass is drained via the DPD and, therefore, pancreatitis with any etiology will be seen most frequently in the dorsal duct region of the pancreas?²

If "obstruction to flow" is the only etiopathogenic factor in the development of PD pancreatitis, then relief of the obstruction at the MiP, either by surgical or endoscopic means, promptly should resolve the pancreatitis. However, long-term results of interventions at the minor papilla have not been satisfactory according to most reports.^{2,19,20}

When knowledge obtained from the review of the literature and personal clinical experience are combined, one cannot help but state that even though PD is the most frequently encountered normal anatomic variant of the pancreatic ductal system and very rarely causes pancreatitis, there are many different sizes of MiPs in each individual—from barely discernible to as large as the major papilla. These different sizes of MiP have to be taken into consideration when trying to explain the pathogenesis of PD pancreatitis.

In the daily practice of endoscopy, large sizes of

MiP often are seen and sometimes are mistaken for major papilla. In cases where there merely is a large MiP, there should be no obstruction at the orifice of MiP and, consequently, no pancreatitis should develop. Unfortunately, no studies have been done to correlate the orifice of MiP, the pressure gradient, and the flow rate of pancreatic secretions in cases of PD with or without pancreatitis. Therefore, the "obstruction to flow" theory, in certain rare cases, still remains unchallenged. Our patient represents such a case. Even in these cases, as seen in our patient, conservative medical management should be given the first priority long before any endoscopic or surgical intervention at the MiP is taken into consideration.

SUMMARY

A typical case of pancreas divisum pancreatitis is presented. Review of the literature on the subject suggests that pancreas divisum is a frequently encountered congenital anatomic variant of the pancreatic ductal system. Its presence alone rarely causes pancreatitis on the basis of "functional obstruction" at the minor papilla. Therefore, endoscopic and surgical interventions, for the purpose of relieving a hypothetical obstruction at the minor papilla, may not be necessary at all. ■

REFERENCES

1. Delhay M, Engelholm L, Cremer M: Pancreas divisum: Congenital anatomic variant or anomaly? Contribution of endoscopic retrograde dorsal pancreatography. *Gastroenterology* 89:951-958, 1985.
2. Steer ML: More doubts about the clinical significance of pancreas divisum. *Gastroenterology* 93:206-207, 1987.
3. Sugawa C, Wait AJ, Nunez DC, Musuyama H: Pancreas divisum: Is it a normal anatomic variant? *Am J Surg* 153:62-67, 1987.
4. Berman LG, Prior JT, Abramow SM, Ziegler DD: A study of the pancreatic duct system in man by the use of vinylacetate casts of postmortem preparations. *Surg Gynecol Obstet* 10:391-403, 1960.
5. Smanio T: Proposed nomenclature and classification of the human pancreatic ducts and duodenal papillae. Study based on 200 postmortems. *Int Surg* 52:125-134, 1969.
6. Soehendra N, Kempeneers I, Nam V Ch, Grimm H: Endoscopic dilatation and papillotomy of the accessory papilla and internal drainage in pancreas divisum. *Endoscopy* 18:129-132, 1986.
7. Rosch W, Koch H, Schaffner O, Demling L: The clinical significance of the pancreas divisum. *Gastrointest Endosc* 22:206-207, 1976.
8. Gregg JA: Pancreas divisum. Its association with pancreatitis. *Am J Surg* 134:539-543, 1977.
9. Mitchell CJ, Lintott DJ, Ruddell WSJ, et al.: Clinical relevance of an unfused pancreatic duct system. *Gut* 20:1066-1071, 1979.
10. Cotton PB: Congenital anomaly of pancreas divisum as cause of obstructive pain and pancreatitis. *Gut* 21:105-114, 1980.
11. Richter JM, Schapiro RH, Mulley AG, Warsaw AL: Association of pancreas divisum and pancreatitis and its treatment by sphincteroplasty of the accessory ampulla. *Gastroenterology* 81:1704-1710, 1981.
12. Cooperman M, Ferrara JJ, Fromkes JJ, Carey C: Surgical management of pancreas divisum. *Am J Surg* 143:107-112, 1982.
13. Gregg JA, Monaco AP, McDermott WV: Pancreas divisum: Results of surgical intervention. *Am J Surg* 145:488-492, 1983.
14. Britt LG, Samuels AD, Johnson JW Jr: Pancreas divisum: Is it a surgical disease? *Ann Surg* 197:654-662, 1982.
15. Russell RCG, Wong NW, Cotton PB: Accessory sphincterotomy (endoscopic and surgical) in patients with pancreas divisum. *Br J Surg* 71:954-957, 1984.
16. McCarthy J, Fumo JDJ, Geenen JE: Pancreas divisum: A new method for cannulating the accessory papilla. *Gastrointest Endosc* 33:440-442, 1987.
17. Schleinitz PF, Katon RM: Blunt-tipped needle catheter for cannulation of the minor papilla. *Gastrointest Endosc* 30:263-265, 1984.
18. O'Connor TLW, Lehman GA: An improved technique for accessory papilla cannulation in pancreas divisum. *Gastrointest Endosc* 31:13-17, 1985.
19. Cotton PB: Pancreas divisum—curiosity or culprit? *Gastroenterology* 89:1431-1435, 1985.
20. Russell RCG: Congenital conditions of the pancreatobiliary tract. *Curr Opin Gastroenterol* 3:679-682, 1987.

PRO Review of Intervening Care

DAVID I. KINGSLEY, MD

The PRO is required to review intervening care provided by outpatient departments, nursing facilities, and home health agencies.

An elderly patient at a skilled nursing facility is admitted to an acute care hospital after fracturing her hip. She is treated and discharged to the skilled nursing facility. Within three weeks, the patient is readmitted to the acute care hospital, having fractured the other hip. An investigation into the case reveals that the nursing staff at the skilled nursing facility failed to secure the latches on the side rail of the patient's bed.

This is one example of a problem in the quality of intervening care being rendered to Medicare patients. In the past, The Peer Review Organization of New Jersey, Inc., has not been authorized to investigate such matters. Under its 1988-1991 Medicare contract with the federal government, The PRO is required to review intervening care provided by hospital outpatient departments, skilled nursing facilities, and home health agencies. This directive is indicative of the government's intent to assess a broader spectrum of health care services.

The cases selected for review by The PRO of New Jersey, Inc., will come from a 25 percent random sample of all acute care hospital readmissions occurring within 31 days of discharge. The initial sample first will be reviewed to assess the care provided in the acute care setting for both hospitalizations. Generic quality screens developed by the Health Care Finance Administration (HCFA) will be used by The PRO's utilization review coordinators (URCs) to assess the medical records. The records will be reviewed for premature discharge from the prior con-

finement, necessity, and appropriateness of both admissions, and the cause(s) and breadth of the problem(s) relevant to the first admission. Any potential quality problems identified by the URCs will be referred to physician reviewers.

All cases in the 25 percent sample of hospital-specific readmissions in which intervening care was delivered to a Medicare beneficiary by a hospital outpatient department, skilled nursing facility, or home health agency will be identified. From that group, a 20 percent hospital-specific sample will be selected for review which will include all cases where initial readmission review indicated a potential quality problem. The purpose of quality review of intervening care is to determine that care met professionally recognized standards, was timely, and was performed in the appropriate setting.

Each case selected for review will be screened by a URC using HCFA-developed generic screens relevant to the site of care. Potential quality problems will be referred to physician reviewers. Confirmed quality problems will be assigned a severity level and weighted score in accordance with the quality interventions program implemented by The PRO of New Jersey under its 1988-1991 Medicare contract.

The PRO's review of intervening care will not include review for medical necessity or overutilization of services as that is the responsibility of the fiscal intermediary. In expanding the scope of work for peer review organizations throughout the country to include intervening care review, the government is endeavoring to ensure that Medicare beneficiaries receive quality care in all health care settings. ■

Dr. Kingsley is president, The PRO of New Jersey, Inc.

Chlamydia Trachomatis

JOSEPH M. LOMBARDO, MD, PhD
CYNTHIA A. SMITH, MT
LILY L. SIDDIQUI, MT
STANLEY J. ROBBY, MD

The frequency of positive serological tests for Chlamydia trachomatis, the most common sexually transmitted pathogen in the United States, was assessed in 18,622 specimens derived from New Jersey clinics. From the results, 13 percent female patients and 17 percent male patients were reactive for chlamydial antigen.

Chlamydia trachomatis has become the most common sexually transmitted pathogen in this country in adults and to newborns.^{1,3} Health costs are estimated in the billions of dollars.⁴ Although the majority of infected individuals are asymptomatic, many develop serious sequelae such as pelvic inflammatory disease (PID), salpingitis, ectopic pregnancy, and reproductive sterility.^{5,9} New estimates indicate upwards of 50 percent of all cases of pelvic inflammatory disease are caused by this infection.¹⁰ The newborn infant of the infected mother may develop conjunctivitis and/or pneumonia; the organism is the most common cause of these maladies in infants less than six months of age.¹¹ In the infected adult male, *Chlamydia* may serve as etiologic agent for epididymitis and rectal proctitis, and may result in sterility.

In June 1987, we reported the results of 3,131 cervical specimens tested for *Chlamydia trachomatis* antigen in individuals attending the Ob-

stetrical and Gynecologic Clinics at University Hospital in Newark.¹² Data now are presented for 18,622 additional specimens accrued during the 30-month period, ending in May 1988, in three geographic zones of New Jersey. Data also are presented on a number of males tested for chlamydial antigen.

SUBJECTS AND METHODS

Nearly all specimens were from women and were derived from the uterine cervix. Of these specimens, 12,419 came from individuals attending either the obstetrical and gynecological clinics, maternal infant care clinic, or the high-risk pregnancy clinic at University Hospital in Newark. University Hospital primarily serves individuals from Essex county and, in lesser numbers, individuals from Hudson, Union, and Morris counties. The remaining 6,203 specimens were derived from well care clinics serving southern portions of New Jersey (Camden, Gloucester, and Cumberland counties). Also, 204 specimens were obtained from the urethras of males who, in most cases, had female partners attending the clinics.

Specimens received from the various clinics at University Hospital were tested for the presence of the *C. trachomatis* antigen by enzyme immunoassay (Abbott Laboratories, Chlamydiazyme®). This tech-

Drs. Lombardo and Robby, and Ms. Smith and Ms. Siddiqui are affiliated with UMDNJ-New Jersey Medical School, Newark. Requests for reprints may be addressed to Dr. Lombardo, UMDNJ-New Jersey Medical School, Department of Pathology, MSB C-544, 185 South Orange Avenue, Newark, NJ 07103.

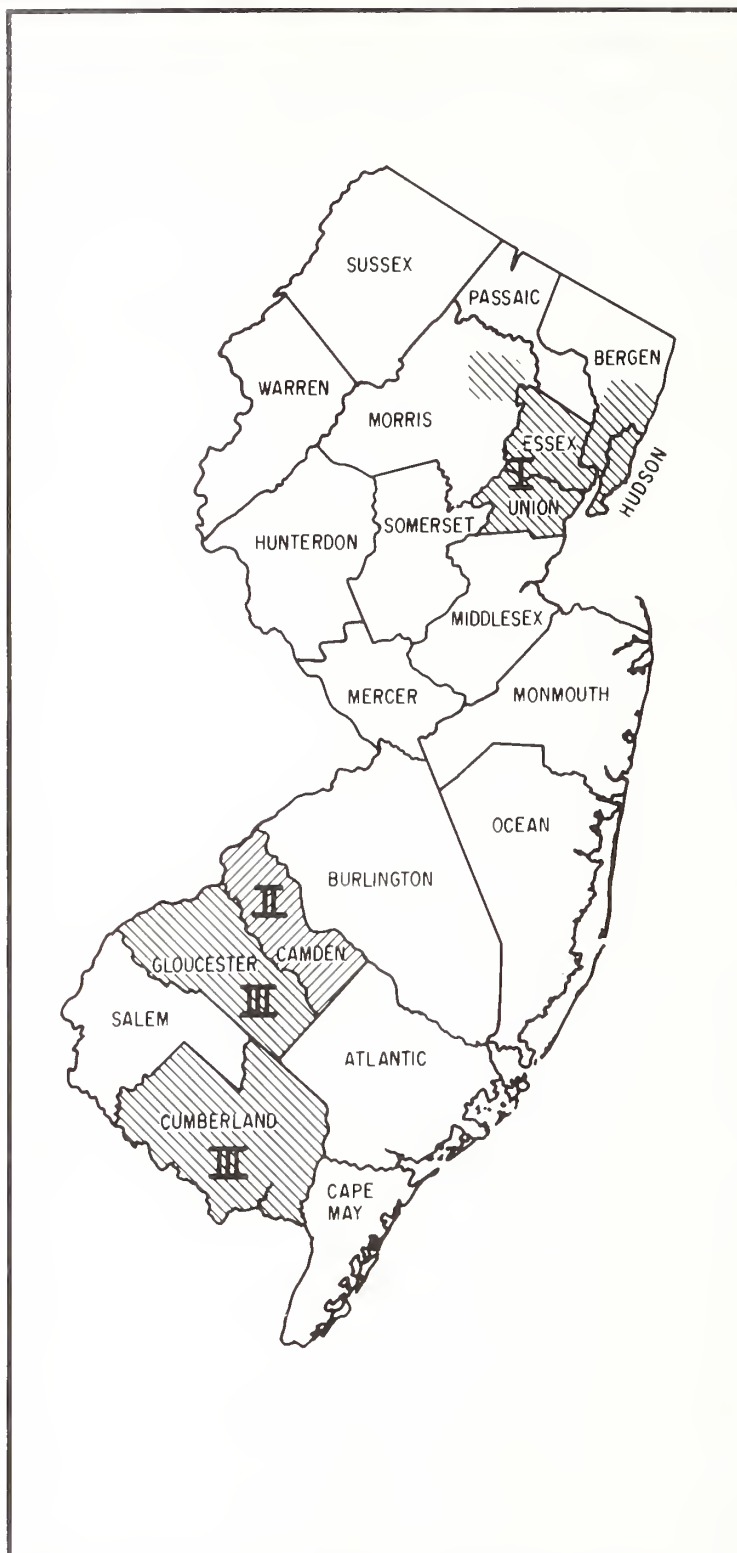


Figure. Geographic distribution of specimens.

nique was performed according to the manufacturer's instructions and the absorbance was determined using a Quantum II spectrophotometer (Abbott).³ A test was considered reactive if the optical density absorbance value exceeded the mean of

the negative controls by 0.10.¹⁴ Specimens derived from individuals attending outside clinics were tested according to the manufacturer's directions, for the presence of *C. trachomatis* antigen by direct immunofluorescence using monoclonal antibody

(Syva, Microtrak[®]).¹⁵ While it has been reported that a single "elementary" body is diagnostic of infection,¹⁶ we interpreted a specimen as reactive only if three or more definitive "elementary" bodies were identified in the smear. Clinics outside University Hospital were more accustomed to the direct immunofluorescence method of detecting *Chlamydia*; that was the major reason for its use in these clinics.

RESULTS

Approximately 13 percent of the 18,622 specimens were reactive for *C. trachomatis* antigen (Table 1); this figure is comparable to the 15 percent reported previously as preliminary data and similar to other reported values, albeit lower.^{12,17} (These differences may be related to the criteria established for defining reactive specimens.) The approximate geographic regions from which the specimens were derived are the three regions illustrated in the Figure. The overall rates from the three regions were similar: region I: 13 percent; region II: 13 percent; and region III: 16 percent.

Data derived from University Hospital (enzyme immunoassay method) are presented in Tables 2 and 4 (region I). Most patients tested were between ages 16 to 30 years (31 percent for 16 to 20 year olds and 52 percent for women aged 21 to 30), and it was these groups that accounted for most positive results. The highest percentage of reactive specimens occurred in the youngest age group (24 percent in 10 to 15 year olds), with a slight decline in the successively older 16- to 20-year-age group (21 percent) and a sharp decline in the 21 to 30 year olds (10 percent) and older than 31 years (4 percent). Similar findings have been reported by others in women under 20.¹⁷

Utilizing a second method to detect the presence of antigen to the same infectious pathogen (direct immunofluorescence), similar results were observed in specimens derived from clinics serving the southern portions of the state (Tables 3 and 4), designated regions II and III.

Specimens derived from region II (Camden county) predominantly are from an urban population. The reported findings are the results of routine screening and, therefore, may approximate prevalence values in this clinic population. In this region

(Table 4), approximately 91 percent of the tests were done on 16 to 20 year olds (45 percent) and 21 to 30 year olds (46 percent) and, as in northern New Jersey, the highest percentage of reactive specimens were found in the 10 to 15 year olds (19 percent) followed by the 16 to 20 year olds (16 percent), and sharply decreasing in the 20 to 30 year olds (10 percent) and older than 31 years (4 percent).

Specimens derived from region III (Gloucester and Cumberland counties) (Table 4) exhibited results similar to regions I and II.

MALES

Among the 204 male urethral specimens tested for *C. trachomatis* antigen by direct immunofluorescence, 17 percent were found to be reactive (Table 5). As with females, most of the male specimens originated from the 16 to 20 year olds (35 percent) and 21 to 30 year olds (49 percent).

Only one specimen came from the 10- to 15-year-age group. Both the youngest interpretable age group (16 to 20 years) and the 21- to 30-year-age group had the highest percentage of reactive speci-

Table 1. Frequency of Chlamydia trachomatis antigen.

Total test number	18,622
Number reactive	2,395
Percent reactive	12.9%

Table 2. Enzyme immunoassay (EIA) method.

Age (years)	Total Tests	Reactive Tests	
		%/Age Group	%/Total
10-15	291	24	4
16-20	3,782	21	50
21-30	6,469	10	41
> 31	1,877	4	5

Table 3. Direct immunofluorescence method.

Age (years)	Total Tests	Reactive Tests	
		%/Age Group	%/Total
10-15	275	19	6
16-20	2,716	17	54
21-30	2,890	11	37
> 31	322	7	3

Table 4. Results of Chlamydia trachomatis antigen testing by region.

	Region I	Region II	Region III
Total Tests	12,419	5,034	1,169
Number Reactive	1,557	655	183
% Total Tests/% Total Reactive/% Reactive in Group			
10-15	2/ 4/24	5/ 6/19	2/ 3/22
16-20	31/50/21	45/56/16	39/52/21
21-30	52/41/10	46/37/10	50/42/13
> 31	15/ 5/ 4	4/ 1/ 4	9/ 3/ 6

Table 5. Male urethral specimens tested by direct immunofluorescence.

Age (years)	Total Tests	Reactive Tests	
		%/Age Group	%/Total
10-15	1	—	—
16-20	72	19	41
21-30	100	19	56
> 31	31	3	3

mens (19 percent) when compared with the over 31-year-age group (4 percent). While the phenomenon observed in female patients, i.e. higher percentage of positive reactions in younger age groups, appears also to occur in males, the percentage of positive reaction is elevated through a wider age range in males than in females before ultimately decreasing.

CONCLUSIONS

This paper reports our laboratory's experience in testing for the presence of *Chlamydia trachomatis* antigen in clinic patients at University Hospital (Newark region) and in regions in other parts of New Jersey (Camden, Gloucester, and Cumberland coun-

ties). Although this report is not a controlled epidemiologic survey, the data, nonetheless, document that *C. trachomatis* infects many residents and that it represents a major health problem.

An association between chlamydial infection and positive seroconversion to human immunodeficiency virus (HIV) has been reported in prostitutes.¹⁸ Such a finding is not unexpected in view of previous reports documenting associations between sexually transmitted diseases (STDs) other than chlamydia with the acquisition or the transmission of HIV.^{19,21}

Recognition that HIV can be transmitted by sexual contact has led to renewed alerts for sexual prudence ("safe sex"). While laudable, such efforts often create a dichotomy between HIV infection and other STDs in the minds of many individuals. Any dichotomy established between HIV infection and other STD is false. STD prevention activities must be aimed ultimately at reducing all STD transmission.²² Our findings suggest that the prudent sexual behavior ("safe sex") necessary to minimize STDs (including HIV) is not being effectively practiced in the large, heterosexually active population studied. ■

REFERENCES

1. Washington AE, Siegel S: *Chlamydia trachomatis* infections: A clinical update. *J Natl Med Assoc* 79:334-338, 1987.
2. Babin V, Ojanlatva A: The impact of *Chlamydia* infections on teen mothers and their children. *J Sch Health* 56:17-19, 1986.
3. Centers for Disease Control: Chlamydia trachomatis infections, policy guidelines for prevention and control. *MMWR* 34:35, 1985.
4. Schachter J: Chlamydial infection: The cost and efficacy of diagnostic testing. *Lab Management* 11:17-21, 1986.
5. Hammerschlag M: *Chlamydia trachomatis*. *Birth Defects* 21:93-108, 1985.
6. Taylor-Robinson D: Don't turn a blind eye to chlamydiae. *Br J Obstet Gynaecol* 91:1169-1170, 1984.
7. Taylor-Robinson D, Thomas BJ: The role of *Chlamydia trachomatis* in genital-tract and associated diseases. *J Clin Pathol* 33:205-233, 1980.
8. Kane JL, et al.: Evidence of chlamydial infection in infertile women without fallopian tube obstruction. *Fertil Steril* 42:843-848, 1984.
9. Schaefer C, et al.: Illness in infants born to women with *Chlamydia trachomatis* infection. A prospective study. *J Dis Child* 139:127-133, 1985.
10. Thompson SE, Washington AE: Epidemiology of sexually transmitted *Chlamydia trachomatis* infections. *Epidemiol Rev* 5:96-115, 1985.
11. Horsburgh, CR, et al.: Preventive strategies in sexually transmitted diseases for the primary care physician. *JAMA* 258:815-821, 1987.
12. Lombardo JM, Siddiqui LL: *Chlamydia trachomatis* antigen. *NJ MED* 84:429-430, 1987.
13. Abbott Laboratories Chlamydiazyme Diagnostic Kit: Enzyme immunoassay for the detection of *Chlamydia trachomatis* in urogenital swab specimens. No. 83-1293/R4, 1985.
14. Chernesky MA, et al.: Detection of *Chlamydia trachomatis* antigens by enzyme immunoassay and immunofluorescence in genital specimens from symptomatic and asymptomatic men and women. *J Infect Dis* 154:141-147, 1986.
15. Syva Microtrak *Chlamydia trachomatis* direct specimen test, No. 8H684-2, revised June 1987.
16. Thomas BJ, et al.: Sensitivity of detecting *Chlamydia trachomatis* elementary bodies in smears by use of a fluorescein labelled monoclonal antibody: Comparison with conventional chlamydia isolation. *J Clin Pathol* 37:812-816, 1984.
17. Bagshaw SN, et al.: Risk factors for *Chlamydia trachomatis* infection of the cervix: A prospective study of 2,000 patients at a family planning clinic. *NZ Med J* 100:401-403, 1987.
18. Plummer F, et al.: Co-factors in male-female transmission of HIV. IV International Conference on AIDS, Abstract 4554. Stockholm, Sweden, 1988.
19. Handsfield HH, et al.: Association of anogenital ulcer disease with human immunodeficiency virus infection in homosexual men. Third International Conference on AIDS, Washington, DC., 1987.
20. Holmberg SD, et al.: Prior herpes simplex virus type 2 infection as a risk factor for HIV infection. *JAMA* 259:1048-1050, 1988.
21. Cannon RO, et al.: Association of herpes simplex virus type 2 with HIV infection in heterosexual patients attending sexually transmitted disease clinics. IV International Conference on AIDS, Abstract 4558. Stockholm International Fairs, Stockholm, Sweden. June 12-16, 1988.
22. Cates W: The other STDs: Do they really matter? *JAMA* 259:3606-3608, 1988.

Unusual Presentation: Testicular Seminoma

GREGORY SZYPULA, MD
PURNENDU SEN, MD
KONG L. TAN, MD
JOHN R. MIDDLETON, MD
MARGARET KUZA, MD

A case of seminoma is described in a patient with HIV infection. The tumor presented atypically with no lymphocytic infiltrates within the stroma. HIV infection has been reported to be associated with an increased incidence of Kaposi's sarcoma, non-Hodgkin's lymphomas, oropharyngeal carcinoma, and pancreatic carcinoma.

The association between viruses and neoplastic diseases is well known.¹ The rapid emergence and spread of human immunodeficiency virus (HIV) infection was followed by the description of multiple clinical syndromes associated with this disease. The clinical features of acquired immunodeficiency syndrome are well described.² However, newer clinical entities continue to be recognized. It has been shown that various neoplastic diseases develop more often in patients

suffering from HIV infection.³⁻¹⁴ Some of the solid tumors in patients with HIV infection may be coincidental; however, some of these neoplasms may occur as a result of alteration of the immune system due to the influence of the human immunodeficiency virus proteins.

We report a case of a testicular seminoma in a young heterosexual male who acquired HIV infection in Africa; and presented one year later with this neoplasm that had an unusual feature.

CASE REPORT

A 35-year-old male was found to have HIV infection by serological tests (ELISA and Western Blot analysis) required for insurance purposes eight months prior to this admission. He was asymptomatic and had no abnormal physical findings. His only risk factor was multiple contacts with prostitutes in central Africa. This population is known to

Dr. Szypula is affiliated with the Department of Medicine, Dr. Sen is program director, internal medicine residency program, Dr. Tan is affiliated with the Department of Pathology, Dr. Middleton is medical director and chairman, Department of Medicine, and Dr. Kuza is affiliated with the Department of Medicine, Raritan Bay Medical Center. Requests for reprints may be addressed to Dr. Szypula, Raritan Bay Medical Center, 530 New Brunswick Avenue, Perth Amboy, NJ 08861.

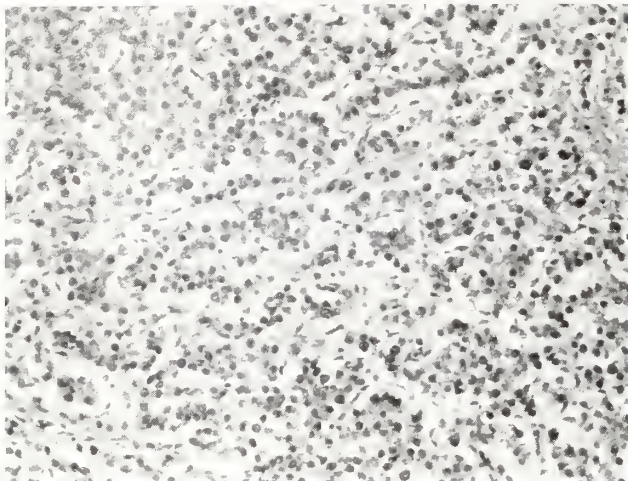


Figure 1. Monotonous neoplastic cells with round hyperchromatic nuclei arranged in cords and tubules. Stroma devoided of lymphocytic infiltrate (hematoxylin and eosin stain, 100 x).

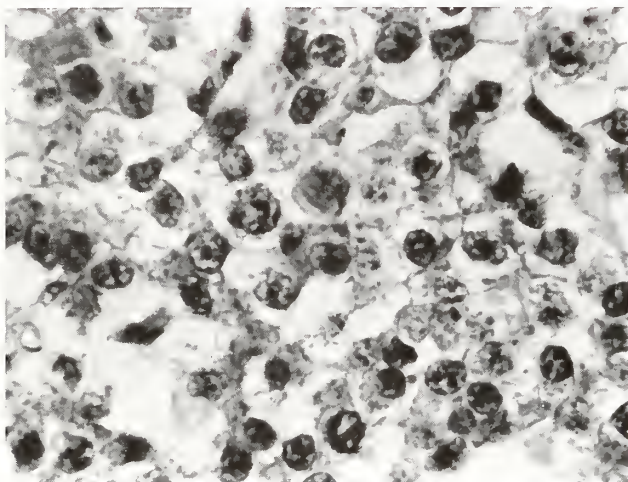


Figure 2. Monotonous neoplastic cells with round hyperchromatic nuclei arranged in cords and tubules. Stroma devoided of lymphocytic infiltrate (hematoxylin and eosin stain, 400 x).

have high prevalence of HIV seropositivity.¹⁵⁻¹⁷ There was no history of homosexual contacts, intravenous drug abuse, or blood transfusion in our patient at this time.

He presented with a two-day history of skin rash that developed after using topical cream for flea bites. There was no history of weight loss, fever, or diarrhea.

The patient exhibited a confluent maculopapular erythematous rash involving the entire body, including the scalp. There were no skin ulcerations or lymphadenopathy. Mucous membranes of the palate and lips showed superficial ulcerations. Oral candidiasis was present. Routine examination of genitalia showed a nontender, hard, left testicular mass, 10 x 5 cm in diameter. The right testicle was normal. The inguinal nodes were not enlarged. The

abdomen was free of masses, and the liver and spleen were not palpably enlarged. There was no peripheral edema.

An erythema multiform type of lesion was diagnosed; subsequently, it improved with the administration of antihistamines.

Pertinent lab data showed: hemoglobin 13.7 g/dl; hematocrit 39.7; WBC 4.7/cm³; platelets 152/cm³; serum aspartate transaminase 65 IU/l, (N = 5-35); lactate dehydrogenase 800 IU/l, (N = 297-537); alkaline phosphatase 139 IU/l (N = 43-122); hepatitis B surface antigen and core antibody were negative; serum B-HCG 20 IU/l; and alfafeto protein 5.0 ng/ml. T-cell subsets study showed: T-4 helper cells of 13, (N = 883 ± 258); T-8 suppressor cells of 128, (N = 507 ± 196); and total T-cell count was 163 (N = 1358 ± 338) indicating marked reduction of helper cells with reversal of T4/T8 ratio.

A computed tomography (CT) scan of the abdomen and pelvis revealed small lymph nodes in the retroperitoneal area. There was no periaortic lymphadenopathy. There was evidence of a left testicular mass of nonhomogenous appearance, suggesting a neoplastic process.

PATHOLOGY

Left orchiectomy was performed. The testis was 9 cm in length. Tunica albuginea was intact. The parenchyma contained a discrete, lobulated, gray-white, bulging, slightly firm mass with focal hemorrhages; it replaced almost the entire testis. A rim of tan compressed testicular parenchyma was present at the margin. Microscopically, the mass was composed of uniform, large polyhedral and round cells with distinct cell borders. The nuclei were central, round, and hyperchromatic with granular chromatin. The cytoplasm was finely granular. Mitosis was absent. These cells were arranged in sheets, lobules, and cords separated by delicate connective tissue stroma without lymphocytic infiltrates or granulomata. Foci of intratubular tumor growth and early infiltration into the epididymis also were seen. No other type of germ cell neoplasm was seen in the multiple blocks examined. Histology was consistent with classical seminoma; however, devoided of typical stromal lymphocytic infiltrates (Figures 1 and 2).

DISCUSSION

The incidence of testicular tumors in the United States is 0.1-1.5 per 100,000 males.¹⁸ Several risk factors have been postulated for this type of tumor, including an association between infection with mumps virus.²⁰ Roseman et al. indicated an association of urogenital cancer with sexually transmitted diseases;²¹ however, no definite conclusion has been established. HIV infection appears to bring a new

possible epidemiological factor.

The most frequent malignancy associated with HIV infection is Kaposi's sarcoma, reported among 34 percent of all AIDS cases and occurring primarily in the homosexual population.^{4,22} Marked increase in the incidence of malignant lymphoma in the population at risk for acquiring HIV infection was reported by Ziegler.^{12,13} Both Kaposi's sarcoma and lymphomas occurring in patients with HIV infection frequently have unusual presentations. Several cases of pancreatic carcinoma, colorectal carcinoma, squamous cell carcinoma of the tongue, and Hodgkin's lymphoma also have been described in patients with HIV infection. Other types of testicular tumors have been described with embryonal carcinoma presenting most frequently.^{24,25,27}

Our patient presented without any of the aforementioned testicular cancer risk factors or fam-

ily history. His seminoma had an atypical histology; lymphocytic infiltrate, the usual feature for this kind of tumor, was absent.

Further clinical evidence is needed to establish an association between HIV infection and testicular seminoma. Those studies also should bring a new insight into a relationship between HIV infection and cancer.

CONCLUSION

Certain neoplasms occur more often in patients with HIV infection. There also may be an association between testicular tumors including seminoma and this disease. The significance of this phenomenon and its impact upon the course of the malignancy remains to be explained. Unusual presentation of tumors should raise suspicion of concomitant infection with human immunodeficiency virus. ■

REFERENCES

1. Wyke J: Principles of leukemogenesis. *Semin Hematol* 23:189-200, 1986.
2. Centers for Disease Control: Definition of HTLV III/LAV infection. *MMWR* 35:335-338, 1986.
3. Ahmed T, Wormser GP, Stahl RE: Malignant lymphomas in a population at risk for acquired immunodeficiency syndrome. *Cancer* 60:719-723, 1987.
4. Fauci AS, Macher AM, Longo DL, et al.: Acquired immunodeficiency syndrome: Epidemiologic, clinical immunologic, and therapeutic considerations. *Ann Intern Med* 100:92-106, 1984.
5. Gold JE, Jimenez E, Zalusky R: Human immunodeficiency virus-related lymphoreticular malignancies and peripheral neurologic diseases. *Cancer* 61:2318-2324, 1988.
6. Groopman JE: Neoplasms in the acquired immunodeficiency syndrome: The multidisciplinary approach to treatment. *Semin Oncol* 14:1-6, 1987.
7. Kaplan MH, Susin M, Pathwa SG, et al.: Neoplastic complications of HTLV-III infection. Lymphomas and solid tumors. *Am J Med* 82:389-396, 1987.
8. Knowles DM, Chamulak GA, Subar M, et al.: Lymphoid neoplasia associated with acquired immunodeficiency syndrome. *Ann Intern Med* 108:744-753, 1988.
9. Levine AM: Non-Hodgkin's lymphoma and other malignancies in the acquired immunodeficiency syndrome. *Semin Oncol* 14:34-39, 1987.
10. Longo DL, Steis RG, Lane C, et al.: Malignancies in the AIDS patient; natural history, treatment strategies, and preliminary results. *Ann NY Acad Sci* 437:421-430, 1985.
11. Selwyn PE: AIDS; what is known. *Hosp Pract* 21:119-153, 1986.
12. Ziegler JL, Beckstead JA, Volberding PA, et al.: Non-Hodgkin's lymphoma in 90 homosexual men. *N Engl J Med* 311:565-570, 1984.
13. Ziegler JL, Bragg K, Abrams A, et al.: High-grade non-Hodgkin's lymphomas in patients with AIDS. *Ann NY Acad Sci* 437:412-419, 1984.
14. Conant MA, Van Fletcher PV, Lozada FI, et al.: Squamous cell carcinoma in sexual partner of Kaposi's sarcoma patient. *Lancet* 1:286, 1982.
15. Brune JB, Ancelle RA: The international occurrence of the acquired immunodeficiency syndrome. *Ann Intern Med* 103:670-674, 1985.
16. Colebunders R, Mann JM, Francies M, et al.: Evaluation of clinical case-definition of acquired immunodeficiency syndrome in Africa. *Lancet* 1:492-494, 1987.
17. Vittecoq D, May T, Roue RT: Acquired immunodeficiency syndrome after traveling in Africa: An epidemiological study of 17 caucasian patients. *Lancet* 1:612-614, 1987.
18. Cutler SJ, Scotto J, Devesa SS, Connelly RR: Third national cancer survey—an overview of available information. *J Natl Cancer Inst* 53:1565-1575, 1974.
19. Graham S, Gibson R, West D, et al.: Epidemiology of cancer of the testis in upstate New York. *J Natl Cancer Inst* 58:1255-1261, 1977.
20. Mostofi FK: Testicular tumors. *Cancer* 32:1186-1201, 1973.
21. Roseman DS, Ansell JS, Chapman WH: Sexually transmitted diseases and carcinogenesis. *Urol Clin North Am* 11:27-43, 1984.
22. Safai B: Pathophysiology and epidemiology of epidemic Kaposi's sarcoma. *Semin Oncol* 14:7-12, 1987.
23. Lowenthal DA, Straus DJ, Campbell SW, et al.: AIDS-related lymphoid neoplasia: The Memorial Hospital experience. *Cancer* 61:2325-2337, 1988.
24. Fenoglio CM, Oster MW, Gerfo P: Kaposi's sarcoma following chemotherapy for testicular cancer in a homosexual man: Demonstration of cytomegalovirus RNA in sarcoma cells. *Hum Pathol* 13:955-959, 1982.
25. Logothetis CJ, Newell GR, Samuels ML: Testicular cancer in homosexual men with cellular immunodeficiency: Report of two cases. *J Urol* 133:484-486, 1985.
26. Sunderam G, McDonald RJ, Maniatis T, et al.: Tuberculosis as a manifestation of the acquired immunodeficiency syndrome (AIDS). *JAMA* 256:362-366, 1986.
27. Welch K, Finkbeiner W, Alpers C, et al.: Autopsy findings in the acquired immunodeficiency syndrome. *JAMA* 252:1152-1159, 1984.

The complete journal for family practice physicians

- Reaches 79,000 family physicians monthly
- Presents the most commonly seen patient problems in family practice
- Written by physicians for physicians
- The most current clinical updates in:
 - Cardiology
 - Pediatrics
 - Psychiatry
 - Diabetes
 - Ob/Gyn
 - Gastroenterology
- Provides 20 hours of CME Category 1 Credit

PRACTICAL • CLINICAL • EDUCATIONAL • CURRENT

Family Practice Recertification Greenwich Office Park 3, Greenwich, CT 06831 / (203) 629-3550

FP R



Epistaxis balloon catheter, page 20

Family Practice Recertification®

DECEMBER 1987 / VOL. 9, NO. 12

FAMILY PRACTICE SKILL

- Controlling Epistaxis

CLINICAL ARTICLES

- Drug Therapy for Manic Illness
- Therapeutic Guidelines for Use of Nonsteroidal
- Antiinflammatory Drugs for Rheumatic Disorders: Salicylates

KEEPING CURRENT

- | | |
|--|---|
| Does a Definite Diagnosis Help Patients Get Better? | Can Obese Type II Diabetic Patients Use Fructose as a Sweetener? |
| Screening for Liver Metastases | Comparison of Diagnostic Tests for Evaluating Dementia |
| Significance of Elevated Erythrocyte Sedimentation Rates | Glucose Tolerance and Pregnancy Complications Among Nondiabetic Women |
| | Psychiatric Reactions Caused by Lidocaine Toxicity |

CUMULATIVE INDEX



**WHEN IT COMES TO YOUR
FINANCIAL HEALTH,
YOU DESERVE A SPECIALIST.**

There's never enough time in the day, or night, to manage a busy health care practice—and its finances. That's why Midlantic National Bank/North created the Medical/Dental Banking Group.

Whether you're starting a new practice, purchasing an established one, or buying into a group practice, see a Medical/Dental Specialist at Midlantic/North. We'll work with you on an individual basis in securing a loan for new equipment, leasehold improvements, or working capital. And, tailor a repayment schedule based on your needs.

If you're just starting out, ask about Midlantic/North's "Healthy Start" Cash Flow Management Program.

To receive our brochure, "A Complete Financial Services Program for Health Care Professionals," speak with Patrick Robinson, our Vice President and Group Manager, at 1-800-633-0040, or (201) 881-5191.

Talk with a Midlantic/North Medical/Dental Specialist, today. Because an ounce of prevention is worth a pound of cure.

Member FDIC
Equal Opportunity Lender

MIDLANTIC
Midlantic National Bank/North
The Hungry Bankers.

Carcinoid Tumor of the Testicle

JOEL W. ROSENBERG, MD
MONICA YANG, MD

Carcinoid tumors commonly are found in the gastrointestinal tract; they rarely are found in the testicle. An illustrative case is presented and the entity discussed. Variables regarding prognosis are reviewed.

Carcinoid tumors are a distinct group of lesions generally arising from the argentaffin cells in the gastrointestinal tract, the gallbladder, and the pancreatic ducts. They also occur in the urinary tract but very rarely are found in the gonads.¹

Carcinoid tumors of the testes are thought to arise in three possible ways: as primary tumors of the testicle (despite the absence of the argentaffin cells); as metastases from gastrointestinal primary lesions; or as one element of a testicular teratoma.¹

A 38-year-old man had a three-week history of a painless mass of the right testicle. Physical examination elicited a rock-hard nodular mass in the upper pole of the right testicle. Scrotal ultrasound showed a calcified mass within the testicle. Serum markers (HCG and alpha fetoprotein) were normal. A radical inguinal orchiectomy was performed.

Pathologic examination revealed a carcinoid tumor, confirmed by special stains for argentaffin cells. Additionally, there was an adjacent area of

calcified epidermal cystic tumor. This was thought to represent a teratoma with carcinoid element (Figures 1A and 1B).

Computed tomography failed to identify any other lesions, i.e. gastrointestinal primary, or evidence of metastatic spread.

Most carcinoid tumors of the testes present with a painless testicular enlargement.² In all but one case in the literature, there is no history of cryptorchidism.³

The classical "carcinoid syndrome" has not been associated with carcinoid tumors of the testes and 5-hydroxy-indole acetic acid (5-HIAA) has not been found in these patients.

The prognosis varies. Tumors that are metastatic to the testicle generally have poor prognosis. The lesions that are primary in the testes, on the other hand, have an excellent prognosis. When the primary testicular tumor is a teratoma, the prognosis varies, according to the elements found in the mixed lesion.

As a rule, treatment has been radical orchiectomy.⁴ A case can be made for retroperitoneal lymphadenectomy but there are not enough cases available to draw firm conclusions. ■

Drs. Rosenberg and Yang are attendings at Passaic Beth Israel Medical Center, Passaic. Requests for reprints may be addressed to Dr. Rosenberg, 721 Clifton Avenue, Clifton, NJ 07013.

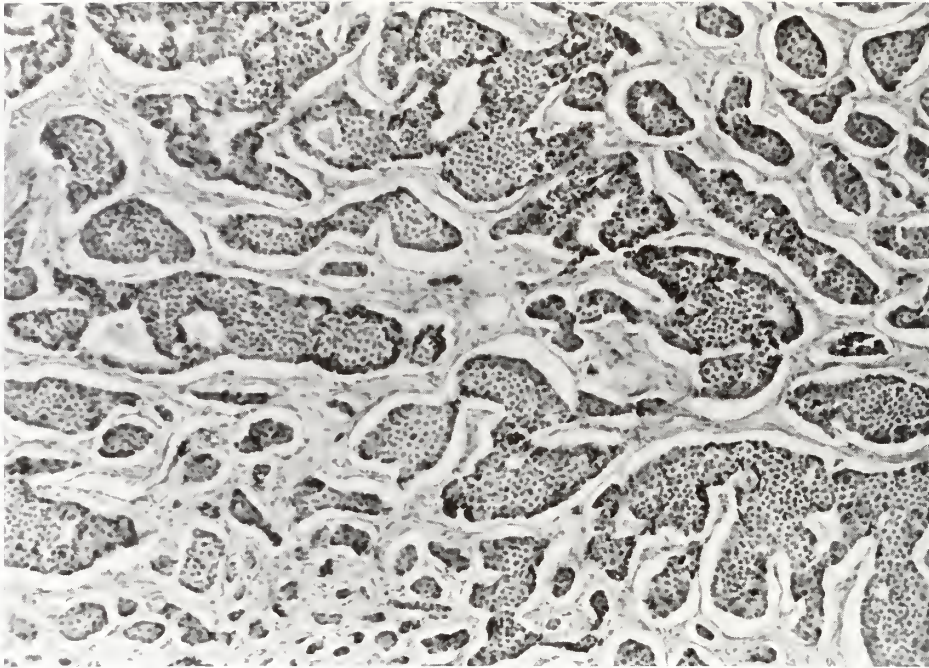


Figure 1A. Standard stain shows typical pattern of carcinoid tumor, indistinguishable from carcinoid tumors of other organs.

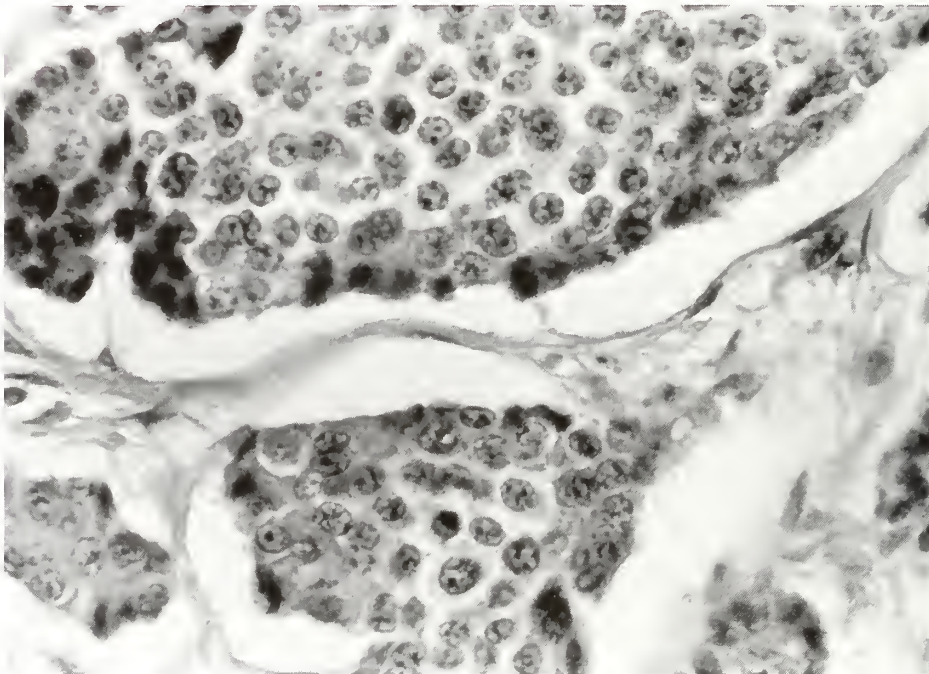


Figure 1B. Argentaffin stain shows typical pattern of carcinoid tumor, indistinguishable from carcinoid tumors of other organs.

REFERENCES

1. Magyar E, Talerman A: Primary carcinoid tumor of the testes. *Urology* X:590-592, 1977.
2. Talerman A, Gratama S, Miranda S, Okagaki T: Primary carcinoid tumor of the testes. *Cancer* 42:2696-2706, 1978.
3. Finci R, Gunhan O, Celasun B, Gungor S: *J Urol* 139:132-133, 1988.
4. Terhune D, Manson AL, Jordon GH, et al.: Pure primary testicular carcinoid: A case report and discussion. *J Urol* 139:132-133, 1988.

Report of the Nominating Committee

Offices To Be Filled by Election 1989 Annual Meeting

Office	Term	Nominee and County
President-Elect	1 year	Douglas M. Costabile, MD, Union
1st Vice-President	1 year	Joseph A. Riggs, MD, Camden
2nd Vice-President	1 year	William E. Ryan, MD, Mercer
Secretary	3 years	Bernard Robins, MD, Essex
Treasurer	3 years	Gerald H. Rozan, MD, Passaic
Trustees		
1st District	3 years	Joel S. Cherashore, MD, Essex
2nd District	3 years	G. Gerson Grodberg, MD, Bergen
4th District	*2 years	Angelo S. Agro, MD, Camden
5th District	3 years	John J. Pastore, MD, Cumberland
Judicial Councilors		
1st District	1 year	**Vacancy
2nd District	3 years	Alden B. Hall, MD, Sussex
5th District	3 years	Paul H. Steel, MD, Atlantic
AMA Delegates		
	2 years	Joseph A. Riggs, MD, Camden
	2 years	Robert H. Stackpole, MD, Union
	2 years	Frank Y. Watson, MD, Essex
AMA Alternate Delegates		
	+2 years	Paul J. Hirsch, MD, Somerset
	2 years	Harry M. Carnes, MD, Camden
	2 years	William E. Ryan, MD, Mercer
	2 years	Donald J. Holtzman, MD, Union
	2 years	Carl Restivo, Jr, MD, Hudson
Administrative Councils		
Legislation		
5th District	2 years	L. Willis Allen, MD, Cumberland
6th Member	2 years	Jerome A. Molitor, MD, Union
Medical Services		
5th District	2 years	Narasimhaloo Venugopal, MD, Cumberland
6th Member	2 years	No nominee named by Nominating Committee
Mental Health		
3rd District	2 years	Douglas H. Robinson, MD, Mercer
6th Member	2 years	William R. Nadel, MD, Union
Public Health		
5th District	2 years	Gerald S. Packman, MD, Cumberland
6th Member	2 years	Glenn P. Lambert, MD, Hunterdon
Public Relations		
2nd District	2 years	No candidate submitted from District
5th District	2 years	No candidate submitted from District
Standing Committees		
Annual Meeting	2 years	Thomas J. Connolly, Jr, MD, Hudson
Finance and Budget	2 years	Matis A. Fernaglich, MD, Bergen
Medical Education	2 years	Sherman Garrison, MD, Cumberland
Membership Services	2 years	John J. Sprowls, MD, Union
Publication	2 years	Clement H. Kreider, Jr, MD, Monmouth

*Unexpired term of George L. Triebenbacher, MD, Ocean County.

**Vacancy created by resignation of Edward M. Coe, MD, effective January 31, 1989, to be filled by nomination and election from the floor.

†Vacancy created by death of George L. Triebenbacher, MD.

CME

Pages 302-308



INTERNATIONAL CONFERENCES™

1989 CME CRUISE/CONFERENCES ON MEDICO-LEGAL ISSUES & RISK MANAGEMENT—Caribbean, Mexico, Alaska/Canada, China/Orient, Scandinavia/Russia, Mediterranean, Black Sea, Trans Panama Canal. Approved for 24-28 CME Category 1 Credits (AMA/PRA) and AAFP prescribed credits. Excellent group rates on finest ships. Pre-scheduled in compliance with IRS requirements.

Information: **International Conferences**, 189 Lodge Ave., Huntington Station, NY 11746. (800) 521-0076 or (516) 549-0869.

June 12-16, 1989

Update Your Medicine 1989. Association of Practicing Physicians of the New York Hospital and Cornell University Medical College. 33½ hour Category I credit (39 if optional workshops are taken). One week review of all subspecialties of internal medicine. Eight major two-hour symposia, nine-hour review lectures, and Medical Ground Rounds. Four workshops will be given for practical problems and management techniques. Optional workshops sessions on Breast/Pelvic and Male Genitoretal examinations. Held at the **New York Hospital-Cornell** 1300 York Avenue at 69th Street, New York. Information: Office of CME, 212-746-4752, or write Rm D-115. Dr. Lila A. Wallis is Course Director.

The Academy of Medicine of New Jersey
The Medical Society of New Jersey
and

The New Jersey Department of Health
Division of AIDS Prevention and Control
present

**Clinical Trials for HIV Infections:
What To Do When the HIV Test Is Positive**

To be held

April 27, 1989

223rd Annual Meeting of the Medical Society of NJ
Sheraton Meadowlands Hotel

May 16, 1989

8:30am-1:30pm

Cherry Hill Inn

May 17, 1989

8:30am-1:30pm

MSNJ Hdqtrs, Lawrenceville

The course is designed to provide physicians and health care professionals with information on identifying persons who need diagnostic testing and how to develop a management strategy for those whose tests are positive. Physicians will learn about formal clinical trials projects in New Jersey and appreciate the necessity for conducting valid clinical trials for HIV infection. They will also understand the practical and ethical difficulties arising from the use of untested treatments where benefits and adverse reactions cannot be evaluated.

Course Chairman: Richard E. Dixon, M.D.

For Further Information on Registration, Faculty, and Fees,
Please Contact:

Susan E. Weeast
Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, New Jersey 08648
Phone: (609) 986-1717



June 17, 1989

**9TH ANNUAL ADVANCES
IN GASTROENTEROLOGY**

Bally's Park Place
Atlantic City, New Jersey

Sponsored by the Gastrointestinal Section of the Hospital of the University of Pennsylvania and the Continuing Medical Education Department of the Underwood Memorial Hospital, Woodbury, New Jersey.

Category 1 credit offered

INFORMATION: Registration Supervisor, SLACK Incorporated, 6900 Grove Road, Thorofare, New Jersey 08086, 609-848-1000.

CONTINUING EDUCATION

ALLERGY

May

- 5 **Allergy Journal Club**
- 12 8 A.M.—New Jersey Medical School, Newark (UMDNJ)

June

- 2 **Allergy Journal Club**
- 9 8 A.M.—New Jersey Medical School, Newark (UMDNJ)

ANESTHESIOLOGY

May

- 16 **Minimizing the Risk in Obstetrical Anesthesia**
Ramada Inn, Clark (NJS Society of Anesthesiologists)

June

- 21 **Pain Therapy**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)

CARDIOLOGY

May

- 3 **Thromboembolism and Thrombolytic Therapy**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove (AMNJ)

June

- 14 **Thrombolytic Therapy**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic (AMNJ)
- 15 **The Dilemmas of Silent Myocardial Ischemia**
12 Noon-1:30 P.M.—Somerset Medical Center, Somerville (Somerset Medical Center)
- 20 **Sudden Cardiac Death**
9-10 A.M.—Holy Name Hospital, Teaneck (AMNJ)
- 21 **Cardiac Rehabilitation**
2:30-3:30 P.M.—Ancora Psychiatric Hospital (AMNJ)

DERMATOLOGY

May

- 17 **Dermatological Conferences**
6-9 P.M.—Rutgers Community Health Center, 57 U.S. Highway 1 South, New Brunswick (UMDNJ)

INFECTIOUS DISEASES

May

- 3 **Psychiatric Aspects of AIDS**
10:30-11:30 A.M.—Christ Hospital, Jersey City (AMNJ)
- 24 **Clinical Management of HIV Infection**
10:30-11:30 A.M.—Christ Hospital, Jersey City (AMNJ and NJDOH)
- 25 **Clinical Management of HIV Infection**
11:45 A.M.-1 P.M.—John F. Kennedy Medical Center, Edison (AMNJ and NJDOH)

June

- 1 **Counseling and Testing for HIV Infection**
11:45 A.M.-1 P.M.—John F. Kennedy Medical Center, Edison (AMNJ and NJDOH)

MEDICINE

May

- 5 **Diabetes Mini-Residency:**
- 24 **Office Management**
10 A.M.-4 P.M.—Carnegie Professional Bldg., Princeton (Princeton Diabetes Treatment & Education Center)
- 5 **Update on Medical Liability Issues**
12 Noon-1 P.M.—Bridgeton Hospital, Bridgeton (AMNJ)
- 8 **Early Office Recognition of Depression**
7-8 P.M.—Wallkill Valley General Hospital, Sussex (AMNJ)
- 11 **Anti-Arrhythmic Therapy**
1:30-2:30 P.M.—Ancora

Psychiatric Hospital (AMNJ)

- 11 **Annual Meeting**
Trump Plaza, Atlantic City (American College of Emergency Physicians, NJ Chapter)
- 12 **New Laboratory Diagnostic Tests**
12 Noon-1 P.M.—Bridgeton Hospital, Bridgeton (AMNJ)
- 12 **Hyperalimentation**
1:30-2:30 P.M.—Vineland Developmental Center, Vineland (AMNJ)
- 15- **Princeton Liposome Conference**
- 16 8 A.M.—Scanticon Conference Center, Princeton (Liposome Company, Inc.)
- 17 **Clinical Trials for HIV Infection**
9 A.M.-12 Noon—MSNJ Headquarters, Lawrenceville (AMNJ, MSNJ, and NJDOH)
- 18 **New Treatments in Cerebrovascular Disease**
2-3 P.M.—John E. Runnells Hospital, Berkeley Heights (AMNJ)
- 18 **How To Live To Be 100**
12 Noon-1:00 P.M.—Somerset Medical Center, Somerville (AMNJ)
- 19 **Hepatitis Review**
10:45-11:45 A.M.—Greystone Park Psychiatric Hospital, Greystone Park (AMNJ)
- 19 **Lipids, Stress, and the Heart**
12 Noon-1 P.M.—Bridgeton Hospital, Bridgeton (AMNJ)
- 23 **The Misdiagnosed Headache**
7-8 P.M.—Molly Pitcher Inn, Red Bank (AMNJ and TMJ Trauma and Headache Center)
- 24 **Intensive Review of Medicine**
8:30-10 A.M.—Alexian Brothers Hospital, Elizabeth (Cornell University Medical College and the National Institutes of Health)



Hahnemann University

DEPARTMENT OF MEDICINE MEDICAL SEMINAR SERIES

Presented by:

William S. Frankl, MD
Professor of Medicine
Chairman, Department of Medicine

Allan B. Schwartz, MD
Professor of Medicine, Deputy Chairman
Graduate Medical Education

Samuel Levit, M.D., Clinical Research Conference

Tuesday, May 9, 1989—4:00 TO 6:00 P.M.

EVOLVING ANTIARRHYTHMIC STRATEGIES: PROCEDURES, DEVICES, and SURGERY

Moderator: Eric L. Michelson, M.D.

Faculty: Leonard S. Dreifus, M.D., Scott M. Goldman, M.D., Steven P. Kutalek, M.D.

This special TUESDAY session will be devoted to a discussion of new cardiac imaging techniques which present clinicians with a bewildering array of high technology choices. The presentations will define current and proposed applications of these newer imaging methods. Emphasis will be placed on the use of MRI with comparison to ultrafast CT.

This special session has been approved for 1.5 Category I CME credits of the Physician Recognition Award of the American Medical Association.

There is no charge for this Tuesday afternoon meeting. However, your advance registration would be appreciated. Please check the appropriate space on the registration form and return to the address given on it.

FACULTY—May 9 and 10, 1989

Course Co-Directors:

Eric L. Michelson, M.D.

Professor of Medicine & Director of Research, Likoff
Cardiovascular Institute, Department of Medicine

Hahnemann University Faculty:

Scott M. Goldman, M.D.

Assistant Professor and Director, Cardiothoracic Surgery
Intensive Care Unit, Department of Cardiothoracic
Surgery

Charles Nydegger, M.D.

Instructor in Medicine, Electrophysiology Section, Likoff
Cardiovascular Institute, Department of Medicine

Steven P. Kutalek, M.D.

Assistant Professor of Medicine and Director, Clinical
Cardiac Electrophysiology, Likoff Cardiovascular
Institute, Department of Medicine

Guest Faculty:

Leonard S. Dreifus, M.D.

(The Samuel Levit, M.D. Honorary Lecturer)
Professor of Medicine, Thomas Jefferson University and
Chief, Cardiovascular Division, Lankenau Hospital

Frank E. Marchlinski, M.D.

Associate Professor of Medicine and Director, Arrhythmia
Evaluation Center, University of Pennsylvania

DEPARTMENT OF MEDICINE WEDNESDAY CME PROGRAM

MAY 10, 1989

A full day devoted to EVOLVING STRATEGIES IN CARDIAC

ARRHYTHMIA MANAGEMENT

- A.M.
8:30 GRAND ROUNDS:
Evolving Diagnostic and Therapeutic Approaches to
Cardiac Arrhythmia Management
Leonard S. Dreifus, M.D.
9:30 CLINICAL ROUNDS:
Leonard S. Dreifus, M.D.
Steven P. Kutalek, M.D.
Eric L. Michelson, M.D.
11:00 CASE PRESENTATION:
Leonard S. Dreifus, M.D.
Steven P. Kutalek, M.D.
Eric L. Michelson, M.D.
Noon LUNCH
P.M.
1:00 MEDICAL SEMINAR SERIES PROGRAM
Pharmacologic Advances in the Management of
Ventricular Arrhythmias
Leonard S. Dreifus, M.D.
1:30 Clinical Approach to the WPW Syndrome
Eric L. Michelson, M.D.

- 2:00 Arrhythmia Mapping, Ablation, and Surgery
Frank E. Marchlinski, M.D.
2:30 Smart Pacemakers and
Antifibrillatory/Antitachycardia Devices
Steven P. Kutalek, M.D.
3:00 Advances in Electrocardiography: Signal Processing
Charles Nydegger, M.D.
3:30 Panel Discussion
4:00 Adjourn

WEDNESDAY CME PROGRAM

MAY 24, 1989

A full day devoted to TREATMENT OF CALCIUM AND BONE METABOLIC DISORDERS

- A.M.
8:30 GRAND ROUNDS:
Steven Marx, M.D.
9:30 CLINICAL ROUNDS:
Steven Marx, M.D.
Carl Salmon, M.D.
11:00 CASE PRESENTATION:
Steven Marx, M.D.
Jeffrey Miller, M.D.
Leslie I. Rose, M.D.
Noon LUNCH
P.M.
1:00 MEDICAL SEMINAR SERIES PROGRAM
1, 25 Vitamin D Receptor in Endocrine Pathology
Steven Marx, M.D.
1:30 Imaging of Parathyroids
Pamela H. Haskin, M.D.
2:00 Pharmacologic Agents in Hypercalcemia
Peter J. Bradford, Ph.D.
2:30 Prevention of Osteoporosis
Jonathan Anolik, M.D.
3:00 Questions and Answers
Leslie I. Rose, M.D., Moderator
3:30 Adjourn

FACULTY

Course Director:

Leslie I. Rose, M.D.

Professor of Medicine and Director, Division of
Endocrinology and Metabolism, Department of
Medicine.

Hahnemann University Faculty:

Jonathan Anolik, M.D.

Pamela H. Haskin, M.D.

Carl Salmon, M.D.

Peter J. Bradford, Ph.D.

Jeffrey L. Miller, M.D.

Guest Faculty:

Steven Marx, M.D.

Chief of Mineral Metabolism Section, National Institute,
Diabetes, Digestive, and Kidney Diseases, National
Institute of Health

Classroom C (Alumni Hall), New College Bldg.
15th & Vine Streets, Philadelphia, Pennsylvania

For further information: Office of Continuing Education, (215) 448-8263

25 Visiting Professor Program
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(*Saint Barnabas Medical Center and AMNJ*)

25 What the Primary Physician Must Know and Do To Save Diabetic Legs
9-10 A.M.—Dover General Hospital and Medical Center, Dover
(*AMNJ and NJDOH*)

June

1 What the Primary Physician Must Know and Do To Save Diabetic Legs
2:30-3:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(*AMNJ and NJDOH*)

6 Annual Symposium
5:15-8:30 P.M.—UMDNJ, New Brunswick
(*NJ Health Sciences Group/ Basic Sciences Section—AMNJ*)

7 Polypharmacy and Psychopharmacology
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic
(*AMNJ*)

7 Annual Joint Meeting
3-9 P.M.—The Manor, West Orange
(*NJ Gastroenterological Society/ NJ Society for Gastrointestinal Endoscopy*)

9- Physician Reimbursement
10 9 A.M.—Holiday Inn, Newark Airport
(*AMNJ*)

12 Hepatitis
12 Noon-1 P.M.—New Lisbon Developmental Center, New Lisbon
(*AMNJ*)

13 Osteoporosis
9-10 A.M.—Holy Name Hospital, Teaneck
(*Holy Name Hospital*)

14 CDS Prescribing Practices: Legal/Illegal
10:30-11:30 A.M.—Christ Hospital, Jersey City
(*AMNJ*)

14 Occupational Medicine
1-2 P.M.—Woodbridge Developmental Center, Woodbridge
(*AMNJ*)

NEPHROLOGY

May

16 Mechanisms of Progression of Chronic Renal Failure

6:30-9 P.M.—Overlook Hospital, Summit
(*Nephrology Society of New Jersey and AMNJ*)

June

7 Annual Scientific Session and Dinner
6:30-9 P.M.—New Jersey Medical School, MEB-108, New Brunswick
(*Nephrology Society of NJ and AMNJ*)

15 Fluid and Electrolyte Imbalance
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(*AMNJ*)

OBSTETRICS AND GYNECOLOGY

June

8- Annual Meeting
10 Trump Plaza Hotel and Casino, Atlantic City
(*NJ Obstetrical and Gynecological Society*)

ONCOLOGY

May

4 Cancer Research Colloquium
11 3-4 P.M.—New Jersey Medical School, G-506B, Newark
18 (UMDNJ)

10 Conservative Management of Breast Cancer
10:30-11:30 A.M.—Christ Hospital, Jersey City
(*AMNJ*)

26 Head and Neck Cancer
7:30-8:30 A.M.—Atlantic City Medical Center, Atlantic City
(*AMNJ*)

June

1 Cancer Research Colloquium
8 3-4 P.M.—New Jersey Medical School, G-506B, Newark
15 (UMDNJ)

22
29
1- Oncology Society of New Jersey, Annual Meeting
Marriott's Castle Harbour, Bermuda
(*Oncology Society of New Jersey and AMNJ*)

PATHOLOGY

May

13 Current Trends in Pathology—1989
9 A.M.-5 P.M.—Somerset Marriott Hotel, Somerset
(*NJ Society of Pathologists and AMNJ*)

30 Clinical Pathology Conference
9-10 A.M.—Holy Name Hospital, Teaneck
(*AMNJ*)

PSYCHIATRY

May

1 New Treatment Approaches in Schizophrenia
8:30 A.M.-12:30 P.M.—Center for Health Affairs, Princeton
(*Division of Mental Health and Hospitals and AMNJ*)

3 Case Seminars To Improve Psychotherapeutic Technique
17 8-10 P.M.—2 West Northfield Road, Livingston
(*Advanced Psychiatric Study Group*)

4 The View from Middle Age
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

5 Psychiatric Lecture Series
19 1:30-3:45 A.M.—Trenton Psychiatric Hospital, Trenton
(*Trenton Psychiatric Hospital*)

26 Early Office Recognition of Depression
7-8 P.M.—Wallkill Valley General Hospital, Sussex
(*AMNJ*)

10 The Violent Hand
All day—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

17 Photo Aging
2:30-3:30 P.M.—Ancora Psychiatric Hospital
(*AMNJ*)

18 Patient's Experience of Illness through Photography
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

19 Medical Aspects of Substance Abuse
12 Noon-1 P.M.—Trenton Psychiatric Hospital, Trenton
(*Trenton Psychiatric Hospital*)

23 Psychological Aspects of Myocardial Infarction
9-10 A.M.—Holy Name Hospital, Teaneck
(*Holy Name Hospital*)

25 Panic Disorder
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

June

1 Brain Grafting: Can We Be Rejuvenated?
12 Noon-1 P.M.—Carrier Foundation, Belle Mead

THE PHILADELPHIA HEART INSTITUTE

Presbyterian Medical Center

CARDIOLOGY UPDATE

designed for the physician and provides an intensive survey of the
current status of clinical cardiology

Wednesday
May 3, 1989
3:00-5:00 PM

Clinical and Angiographic Findings in Coronary Heart Disease

Moderator:

Bernard L. Segal, M.D.

- 3:00-3:30** What is silent ischemia and is it different from
symptomatic ischemia? Diagnostic and prognostic
implications Ami S. Iskandrian, M.D.
- 3:30-4:00** Is coronary arteriography the "gold standard" for evaluating
coronary heart disease? John W. Hirshfeld, M.D.
- 4:00-5:00** Case presentations Pingkwan A. Chan, M.D.
Panel discussion Jai B. Agarwal, M.D.,
Harold R. Kay, M.D., Peter G. Lavine, M.D.,
J. David Ogilby, M.D., Henry S. Sawin, M.D.

- No Registration Fee
- Reception following session
- CME Credits*
- Call for Reservation 662-8627

* * *

Scheie Eye Institute Auditorium
Presbyterian Medical Center
39th and Market Streets
Philadelphia, Pennsylvania
Parking Available (at discount rate).

* * *

* The University of Pennsylvania School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing education for physicians. The University of Pennsylvania School of Medicine designates this continuing medical activity for 2 credit hours per session in Category I of the Physicians Recognition Award of the AMA.

(Carrier Foundation)

- 2 **Psychiatric Lecture Series**
9 1:30-3:45 P.M.—Trenton
16 Psychiatric Hospital, Trenton
(Trenton Psychiatric Hospital and AMNJ)
7 **Case Seminars To Improve**
21 **Psychotherapeutic Technique**
8-10 P.M.—2 West Northfield Road, Livingston
(Advanced Psychiatric Study Group and AMNJ)
8 **Recent Research Advances in Teenage Suicide**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)
14 **Psychoneuroimmunology**
All day—Carrier Foundation, Belle Mead
(Carrier Foundation)
15 **The Adolescent Sexual Offender**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)
29 **Doctor-Patient Relationship and Noncompliance**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

PULMONARY

May

- 2 **Pulmonary Conferences**
9 8-9 A.M.—New Jersey Medical School, H-349, Newark
(UMDNJ)
29
2 **Pulmonary Case Conferences**
9 8-9 A.M.—University Hospital, New Brunswick
(UMDNJ)
29

June

- 6 **Pulmonary Conferences**
13 8-9 A.M.—New Jersey Medical School, H-349, Newark
(UMDNJ)
27
6 **Pulmonary Case Conferences**
13 8-9 A.M.—University Hospital, New Brunswick
(UMDNJ)
27

RADIOLOGY

May

- 18 **Radiological Society of New Jersey Meeting**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of NJ and AMNJ)
31 **Radiology Meeting**
6:30-10 P.M.—The Manor,

West Orange
(AMNJ)

SURGERY AND ITS SPECIALTIES

May

- 2 **Surgical Grand Rounds**
9 7-9 A.M.—Hackensack Medical Center, Hackensack
16
(Hackensack Medical Center and AMNJ)
30
3 **Surgery—Contenance Preserving Operations for Ulcerative Colitis and Familial Polyposis**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic
(AMNJ)
4- **Third Annual Meeting**
7 Southhampton Princess Hotel, Bermuda
(Eastern Vascular Society)
10 **Conservative Management for Breast Cancer**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)
23 **Head and Neck Surgery**
8-10 P.M.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

June

- 7 **In and Out Surgery**
10:30-11:30 A.M.—Christ

Hospital, Jersey City
(Christ Hospital and AMNJ)

- 23 **Surgical Treatment of Morbid Obesity**
7:30-8:30 A.M.—Atlantic City Medical Center, Atlantic City
(AMNJ)

UROLOGY

May

- 10 **Urology Rounds**
6:20-8:30 P.M.—Robert Wood Johnson Medical School, 108B, New Brunswick
(UMDNJ)
10 **Urology**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic
(AMNJ)
17 **William P. Burpeau Award: Endoscopic Ultrasonic Aspiration of the Prostate and Bladder Cancer**
6:30-10 P.M.—Ramada Renaissance Hotel, East Brunswick
(AMNJ)

June

- 14 **Urology Rounds**
6:20-8:30 P.M.—Robert Wood Johnson Medical School, 108B, New Brunswick
(UMDNJ)

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Category: (Please check one)

☐ Member, MSNJ ☐ Subscriber, NJ Medicine

☐ Other _____

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____



Hahnemann University

DEPARTMENT OF MEDICINE

MEDICAL SEMINAR SERIES

Presented by:

William S. Frankl, MD

Professor of Medicine

Chairman, Department of Medicine

Allan B. Schwartz, MD

Professor of Medicine, Deputy Chairman

Graduate Medical Education

WEDNESDAY CME PROGRAM

APRIL 26, 1989

A full day devoted to

TREATMENT OF HYPERTENSION IN THE BLACK POPULATION

A.M.

8:30 GRAND ROUNDS:

Stepping away from Stepped Care: Rational Use of
Antihypertensive Therapy for Black Patients

Elijah Saunders, M.D.

Smoking and Hypertension in Black Patients

Barry J. Materson, M.D.

9:30 CLINICAL ROUNDS:

David Kountz, M.D.

Vince Quinn, M.D.

11:00 CASE PRESENTATION

David Kountz, M.D.

Noon LUNCH

P.M. MEDICAL SEMINAR SERIES PROGRAM

1:00 Special Techniques for Detection and Management of
Hypertension in the Black Population

Elijah Saunders, M.D.

1:30 Changing Concepts of Central Hypertension:

New Tiles in the Mosaic

Barry J. Materson, M.D.

2:00 Management of High Blood Pressure in Black Juveniles

Bonita Falkner, M.D.

2:20 Coffee Break

2:40 Treatment of Adult Black Hypertension

Charles Swartz, M.D.

3:00 Retinopathy of Hypertension

Stephen H. Sinclair, M.D.

3:20 Hypertension Crisis Treatment

Allan B. Schwartz, M.D.

4:00 Cardioprotective Consideration of Treatment of
Hypertension

Ilene Pina, M.D.

4:30 Adjourn

Hahnemann University Faculty

Course Director: Charles Swartz, M.D.

Professor of Medicine and

Director, Division of Nephrology

Department of Medicine

Bonita Falkner, M.D.

David Kountz, M.D.

Ileana L. Pina, M.D.

Vince Quinn, M.D.

Stephen H. Sinclair, M.D.

Allan B. Schwartz, M.D.

Guest Faculty

Elijah Saunders, M.D.

Associate Professor of Medicine and Chief,

Hypertension Division

University of Maryland Hospital

Barry J. Materson, M.D.

Professor of Medicine and Associate Chief of

Medical Service

Miami Veteran's Administration Medical Center

Classroom C (Alumni Hall), New College Bldg.

15th & Vine Streets, Philadelphia, Pennsylvania

For further information: Office of Continuing Education
(215) 448-8263

Rubin, Rubin & Malgran

ATTORNEYS AT LAW

(201) 463-7500

SERVING THE MEDICAL PROFESSION IN DISCIPLINARY MATTERS

Call on our experienced staff of attorneys when
charges threaten your professional standing.
Our firm possesses the experience and re-
sources to assure your rights will be protected.

WE CAN MAKE YOUR LIFE EASIER

with practice management services by

Rosewood Medical Management

- Improve accounts receivable
- Decrease billing problems and complaints
- Always courteous to your patients when they call
- Improve diagnosis and procedure coding accuracy
- Optimize third party reimbursements
- Electronic claim submission:
Blue Shield of New Jersey
Medicare

All specialties

For further information, contact Valerie Wood



Rosewood

MEDICAL MANAGEMENT, INC.

27 MECHANIC STREET

RED BANK, NJ 07701

(201) 576-8100

NOTEBOOK

UMDNJ NOTES

New Jersey's first liver transplant was performed at the University of Medicine and Dentistry of New Jersey's University Hospital, in Newark. The patient, a 29-year-old Passaic man who had severe liver failure, is in stable condition and continues to do well. But it still is very early in the recovery process and we are keeping a close watch on his condition. He would not have lived for very long without this procedure.

The hospital had been preparing for the state's first liver transplant since UMDNJ gained authorization in August 1987, when state Health Commissioner Molly Coye signed the enabling certificate of need. The designation recognized University Hospital's expertise in the field of liver disease through its affiliation with the Sammy Davis Jr. National Liver Institute, also based at our Newark campus.

The procedure—the most complex of all transplant operations—puts the University in the forefront of sophisticated medicine. New Jerseyans no longer have to leave the state to find this kind of leading-edge care. And, New Jersey physicians can feel confident in referring patients to the Sammy Davis Jr. National Liver Institute.

The transplant surgery was performed by a team headed by Dr. Baburao Koneru, director of the Liver Transplant Program at University Hospital. Dr. Koneru was assisted by Dr. Dorian Wilson, associate director of the program and a graduate of UMDNJ.

The patient, who had been under the care of Dr. Carroll Leevy, was in University Hospital when a donor liver became available for transplantation. Dr. Leevy is professor and chairman of medicine at New Jersey Medical School and scientific director of the Liver Institute.

A new Sickle Cell Center that specializes in adults with sickle cell anemia and other red blood cell disorders has been opened in Camden by our School of Osteopathic Medicine.

The Center offers diagnosis, treatment, education, counseling, and psychosocial support, and provides continuity of care for young adults who may have been previously enrolled at sickle cell programs for children. The Center provides a team approach to care through a staff that comprises three physicians, a nurse clinician, counselors, and support staff. In addition, specialists from virtually every branch of medicine are available from the medical school faculty.

Joining Dr. Freed in the program are Dr. Sandra Hollander, assistant professor of clinical medicine and co-director, nurse clinician Shirley Mendolia, and Dr. Harvey Rothman, associate professor of clinical medicine.

Tests to diagnose the early stages of gastric ulcers and Sjögren's syndrome, also known as dry mouth, a common disease of the elderly, have been developed at UMDNJ-New Jersey Dental School.

In both cases, the breakthrough tests involve microscopic analyses

of saliva for telltale elements that reveal the ailments early-on or show that conditions are ripe for their development. Steps then can be initiated to help prevent the conditions from advancing.

In the case of gastric ulcers, the tip-off elements are enzymes that previously were identified in bacteria associated with the ulcers. It is hoped that the new test, in many instances, will eventually substitute for endoscopy.

Two diagnostic tests have been developed for Sjögren's syndrome, a condition afflicting some 85 percent of the elderly and commonly leading to arthritis. In one of these tests, the predictive sign is the level of lipids in the saliva. Those developing the condition have 20 percent higher levels of these fats than normal.

In the other test, a stained monoclonal antibody is introduced into the saliva to find and bind to mucus glycoprotein. If tests reveal a cluster of the stained antibodies, the dry mouth disorder is confirmed.

In most cases, the more sophisticated antibody procedure would be used to confirm the simpler lipid-level method.

The new tests will help physicians recognize the disorder and then take steps to minimize or prevent it before it leads to arthritis.

Sjögren's syndrome breaks down the protective qualities of saliva, leaving the gums and teeth susceptible to decay. It particularly is prevalent in postmenopausal women.

The saliva tests are experimental and not yet available to the

public. They are part of ongoing research by the dental school's Dental Research Center into the relationship between the salivary gland and disease. The studies, funded through nearly \$4 million in grants from the National Institutes of Health, involve developing a saliva test for cystic fibrosis and documenting the effects of alcoholism on the alimentary tract.

□ Stanley S. Bergen, Jr, MD

MSNJ AUXILIARY

An expert in health law and an Auxiliary member from Gloucester County, Claire Connor Obade, Esquire, will be the featured speaker at the MSNJ Auxiliary's Annual Session on Friday, April 28, 1989, at 2:00 P.M. in the Seminar Room at the Sheraton Meadowlands Hotel, East Rutherford. Ms. Obade, a partner in the Philadelphia law firm of Saul, Ewing, Remick and Saul, will discuss, "Critical Care Decision Making." She will elaborate on the clinical dilemmas which raise legal liabilities for physicians: treatment of patients who are terminally ill or irretrievably comatose, and other patients who present difficulties in clinical decision making.

Specific topics to be covered are: patient decisions to withdraw or withhold treatment; living wills; do not resuscitate orders; decisions by others to withdraw or withhold treatment from the incompetent patient; circumstances which obligate the physician to intervene and provide treatment against the wishes of the patient or those persons purporting to have authority to decide for the patient; and the propriety of a physician's obtaining guidance from institutional prognosis or bioethics committees, or the courts, when uncertainty exists in regard to providing treatment.

Ms. Obade graduated with honors from the Pennsylvania Hospital School of Nursing in 1970 and

received her juris doctor degree from the University of Pennsylvania in 1981. She is the author of several articles on health care law and frequently lectures on health law issues pertaining to bioethics, privacy and confidentiality, informed consent, medical staff credentialing, and other professional practice and regulatory matters.

Auxiliary President Angie Campo invites all members of the Medical Society and their spouses to attend the special Friday afternoon program.

The Auxiliary also extends an invitation to all MSNJ members to attend the AMA Adviser's seminar on April 27, 1989, from 2:00 P.M. to 3:30 P.M. The program, given by the Financial Services and Investment Counseling Organization owned by the AMA, concerns present and future investment trends and offer physicians suitable investment and retirement planning strategies.

In addition, the Auxiliary is including physicians in its Annual Session's Arts and Crafts Exhibit. The physicians' category is photography—limited to landscapes and portraits. Registration will be held on Friday, April 28, 1989, from 10:30 A.M. to 4:30 P.M. in the Derby Ballroom. Entry blanks can be obtained that day or in advance by calling MSNJ Auxiliary headquarters. □ Marion H. Geib

LEGISLATION

The following listing contains bills of medical importance to MSNJ. MSNJ's position is indicated at the end of each item.

S-1938—Pallone—Medical Waste. Requires that all medical waste be incinerated by a licensed center. Manifest records must be maintained by the generators, i.e. doctors, dentists, hospitals, the transporters, and the incinerators. **No Action.**

S-2858—Lesniak—No Fault. Makes PIP coverage optional if the insured has other health coverage. **Dis-**

approved, many drivers do not have health insurance and many persons that do have it, because of employment or student status, become ineligible. This bill would produce many gaps in coverage and, consequently, result in service disruption.

S-2907—Bassano—Medicaid. Extends hospice coverage to Medicaid. **Approved.**

S-2918—Codey—Lupus Registry. Declares lupus a reportable disease and creates a registry within the Department of Health. **Disapproved,** already being done on a national level. State Public Health Council has the authority to establish a registry when indicated.

S-2919—Codey—Lupus Treatment. Creates a lupus treatment demonstration project within the Department of Health with a seven-person advisory committee. **Disapproved,** education and treatment program already being done in physicians' offices throughout state.

S-2920—Codey—Medical Waste. Provides for rewards for reports which lead to the conviction of illegal medical waste disposers. **Disapproved,** bounty systems encourage reckless conduct. If there is validity to the concept, it should first be tested for the crimes of murder, rape, and robbery.

S-2921—Russo—Drug Abuse. Establishes a Governor's Council on Alcoholism and Drug Abuse to coordinate the various programs by various governmental agencies. **Disapproved,** since both divisions have functioned well separately, there is no need for this legislation.

S-2936—Codey—Medical Licensing and Discipline. This bill would revise the current State Board system by requiring enhanced and more comprehensive reporting of impaired or incompetent physicians. At the same time it removes the SBME and the attorney general's office from certain conflicts by having a separate panel make initial decisions. A clear burden of proof is established and further enhancements regarding due process have been recommended by MSNJ special counsel, Herbert J. Stern. **Conditional Approval,** pending acceptance of amendments to the bill as submitted by MSNJ.

S-2939—VanWagner—Emergency Services. Appropriates \$1.5 million to

the Department of Health to be used for EMS training and equipment. **Action Deferred**, pending further information from MSNJ's Committee on Emergency Medical Care.

A-2947—Orechio—AIDS. Requires the Department of Health to file reports related to ARC, AIDS, and HIV positive patients to local health officers on a regular basis. **Disapproved**, local health officers currently have access to these statistics.

A-124—Villane—Medical Waste. Regulates the disposal of medical waste through a complex system which would require every doctor and dentist to register with the Department of Health and to use a manifest system which includes the filing of detailed quarterly reports. **No Action.**

A-1718—Martin—Nursing Education. Directs Rutgers to establish a doctoral program in nursing. **Approved.**

A-1734—Martin—Drug Testing/Student Athletes. Requires high school students to be tested for drug abuse. **Action Deferred**, pending further information from MSNJ's Committee on Drug and Alcohol Abuse and Committee on Medical Aspects of Sports.

A-1774—Kern—Governor's Council on Substance Abuse. Creates a 24-member Governor's Council on Alcoholism and Drug Abuse and merges the existing Division of Alcoholism and the Division of Narcotic and Drug Abuse Control within the Department of Health into a new Division of Alcoholism and Drug Abuse Control. It would coordinate all programs within the state and make program and funding recommendations to the governor and the Legislature. The governor is to appoint an independent evaluator who would conduct a study and file a report on the efficacy of the Council four years after enactment of the legislation. **Disapproved**, since both the Division of Narcotics and Drug Abuse Control and the Division of Alcoholism function well as separate divisions, there is no need for this legislation.

A-2512—Bush—Health Insurance/Mammograms. Provides that health insurers must pay for mammograms. It does not apply to routine screening. **Approved.**

A-2524—Miller—AIDS. Requires a physician to disclose positive results of

AIDS test to patient's spouse. **Conditional Approval**, pending the following amendments: 1. The word "spouse" be changed to "known sexual contacts and needle-sharing contacts." 2. Positivity must be verified by a confirmatory test. 3. In Line # 11 the word "shall" be changed to "may" and in the statement the word "require" be changed to "urge." 4. Throughout the bill "HTLV III" be changed to "HIV." It was further recommended that if the sponsor objects to any of the foregoing amendments that MSNJ change its position to **Disapproved**. □

A-2672—Zecker—Pension Funds. Exempts pension funds from attachment except in family law cases. **Approved.**

A-3476—Colburn—Uncompensated Care. Restricts uncompensated care reimbursement at 7 percent; pays 97 percent of the excess with state monies; deducts the remaining 3 percent from hospital revenues; requires hospitals to accept Medicaid rates for indigent emergency room cases. **No Action.**

A-3563—Kern—AIDS. Authorizes disclosure to certain person of parolees with AIDS. **Disapproved**, the bill, as written, has no provisions for confidentiality and there is no companion bill or current legislation which requires reporting by any governmental organization of HIV positivity.

A-3677—Spadaro—Medical Waste. Makes it a crime to dispose of medical waste other than in compliance with the Solid Waste Management Act. **Action Deferred**, pending further information from MSNJ's Committee on Environmental Health.

A-3736—Duch—Criminal Responsibility. Provides for the commitment of persons who are acquitted because of mental disease or defect if the defendant is a danger to himself or others. **Action Deferred**, pending further information from MSNJ's Council on Mental Health.

A-3737—Duch—Home Health Care. Establishes a demonstration project within the Department of Human Services to provide home health care to functionally and cognitively impaired seniors or disabled persons under the Social Security Act. **Approved.**

A-3738—Girgenti—Orthotists and Prosthetists. Provides for the licens-

ing and regulation of orthotists and prosthetists through an advisory committee in the Division of Consumer Affairs. Physicians are exempted from the requirements of the act. **Action Deferred**, pending further information from the New Jersey Orthopaedic Society.

A-3781—Roma—Health Insurance. Requires all health insurers to provide reimbursement for mammograms, pap smears, and infertility tests. (The bill does not state clearly whether screening tests are included). **Action Deferred**, pending further clarification of the bill to determine whether routine screening is included in the reimbursement.

A-3790—Otlowski—Involuntary Commitment. Changes the effective date of P.L.1987, c.116 from May 1989 to November 1989. **No Action.**

A-3804—Littell—Ambulance, Fire, Rescue Squads. Prohibits the formation of local, regional, or statewide EMS coordinating areas. **Action Deferred**, pending further information from MSNJ's Committee on Emergency Medical Care.

A-3819—Schluter—No-Fault. Establishes a verbal threshold. Suits would be allowed for noneconomic loss only when the injury resulted in death, serious impairment of a body function, or permanent serious disfigurement. **Approved.**

A-3838—Randall—Hospital Records. Authorizes the commissioner of health to set fees for the copying of hospital records. **Disapproved**, because the bill is an unnecessary intrusion into management function.

A-3842—Bush—Blood Donors. Allows persons over age 65 to donate blood. **No Action** (unnecessary legislation).

A-3843—Bush—Infant Mortality. Creates a commission on infant mortality consisting of 15 members. Four members would be physicians. **Approved.**

A-3844—Bush—Cancer Research. Provides that a portion of the surtax on cigarettes be dedicated to the Cancer Research Fund. **Approved.**

A-3880—Moran—Podiatry. Declares that podiatrists are "physicians" within the scope of their licensing act. **Disapproved**, because of the wording of such legislation would mislead the public into assuming that

"podiatrists" are fully licensed physicians. If the intent of this bill relates to insurance reimbursement, it should be drafted to change the insurance code.

A-3933—Stuhltrager—Medicaid. Requires Medicaid program to cover hospice services. *Approved.* □

NEW MEMBERS

The Medical Society of New Jersey would like to welcome the following new members:

Atlantic County

Peter J. Costantini, DO
Mary R. Scanlon, MD

Bergen County

Richard D. Baum, MD
David G. MacKinnon, MD
Mark J. Rametta, DO
Frank J. Rini, MD
C. A. Scheraldi-Nunez, MD
Kathleen D. Stokes, MD

Burlington County

Jay L. Bloch, MD
Michael B. Chancellor, MD
Konstantin Dateshidze, MD
Anthony DelConte, III, MD
Louis C. DeMaria, Jr, MD
Maurice D. Leonard, MD
Bernardita M. Maure, MD
Wilfredo M. Mediano, MD
Allen J. Steinberg, MD
Kenneth R. Stone, MD

Camden County

Ramon Acosta, MD
Umur M. Atabek, MD
Anthony J. DelRossi, MD
Robert L. Gardine, MD
Carl F. Hyder, MD
Kathleen M. Kean-Goldstein, DO
Bonnie L. Levin, DO
Hemangini H. Mehta, MD
Salvatore M. Moffa, MD
Scott R. Schaffer, MD
Theresa M. Welsh, MD

Cape May County

Mark R. Sorensen, MD

Essex County

Jordana Baum, MD

Elliot B. Bodofsky, MD
Kristina E. Bulas, MD
Denise I. Campagnolo, MD
Alice J. Cohen, MD
Charles J. Crane, MD
Cynthia A. Cuffie, MD
Emilio Del Valle, MD
Clarence A. Foye, MD
Silvana Gaudino, MD
David I. Hollander, MD
Kuei-huang Huang, MD
Walter G. Husar, MD
Andrew M. Hutter, MD
Joseph L. Ianello, MD
Julius A. Kaplan, MD
John V. Kelly, Jr, MD
Kevin J. Kerlin, MD
Willem T. Kuiper, MD
Rhonda R. Nichols, MD
Sabina M. Porcaro, MD
Thomas J. Rojy, MD
Jeffery W. Seitzinger, MD
S. Vaithiasaram, MD
Richard Verdoni, MD

Gloucester County

Ashok R. Bapat, MD
Rosanne G. Frost, MD
Joseph B. Szgalsky, MD
John A. Vergari, Jr, MD

Hudson County

Spartaco Bellomo, MD
Peter F. Cheng, MD
Daniel Y. Chu, DO
Julie M. Di Gioia, MD
Stephen C. Hall, MD
Robin J. Iversen, MD
Richard G. Lon, MD
Leticia S. Luna, MD
Dominic J. Maiello, MD
Adela M. Peralta, MD
Alan B. Port, MD
Jay I. Stylman, MD

Mercer County

Thomas K. Evans, MD
Richard J. Friedland, MD
Samuel H. Friedman, MD
Linda G. Gochfeld, MD
Richard K. Goodstein, MD
Lawrence J. Jordan, III, MD
Mary E. Kazanski, MD
Andrew C. Lipka, MD
Brian E. O'Byrne, MD
William Schillizzi, MD

William D. Stanley, MD
Michael E. Tofano, MD
Linda D. Van Pelt, MD

Middlesex County

Sheryll A. Bryan, MD
Magdy A. Chaly, MD
William C. Chiu, MD
Rafael Crespo, MD
Vinod K. Dasika, MD
Jacob Dorfman, MD
Martin L. Evers, MD
Elissa A. Favata, MD
Stanley K. Fishman, MD
Magdy A. Ghaly, MD
Thomas Hegyi, MD
I. Mark Hiatt, MD
John A. Just, MD
John L. Lundberg, MD
Richard A. Medina, MD
Orlando F. Mills, MD
Patricia B. Nee, MD
William D. Pantel, MD
Aldonia A. Swamy, MD
Marie C. Trontell, MD
Lloyd Zucker, MD

Monmouth County

Philip L. Case, MD
Khalid Y. Khan, MD
Nafi Kiremitci, MD
Jyothsna S. Shastry, MD

Morris County

Steven L. Armus, MD
Lisa M. Bonaventura, MD
William L. Diehl, MD
Robert S. Freid, MD
Edward J. Zampella, MD

Ocean County

Oscar F. Bernardez, MD
Barry S. Friter, MD
Richard C. Hartwell, MD
Joel H. Kurtz, MD
Andrew L. Simon, MD
Wilda I. Smithers, MD

Passaic County

Anil Agarwal, MD
Thomas C. Baldacchino, MD
James A. Baratta, MD
Toni Centanni, MD
Michael J. Eisenberg, MD
Elizabeth A. Hawruk, MD

Josephine Jasper, MD
James M. Katz, MD
Craig S. Rosenblum, MD
Mariamma Thomas, MD
A. Gabriella Weiss, MD
Emmanuel M. Weiss, MD

Somerset County

Robert J. Caccavale, MD
Susan L. Cooley, MD
William H. Kranichfeld, MD
Ronald J. Massari, MD
Susan M. Rowley, MD

Sussex County

Peter G. Lohwin, MD

Union County

Karpukarasi Ayyanathan, MD
Robert Bayly, MD
Andrew D. Beamer, MD
James H. Frost, MD
Alice B. Gibbons, MD
Frances M. Hulse, MD
Chandran K. Kunjan, MD
Jeffrey B. Magnes, MD
Martin P. Mayer, MD
Nirmal K. Mittra, MD
Benjamin G. Piantedosi, MD
Peter J. Snieckus, MD
Kenneth J. Storch, MD
Claudia A. Wagner, MD

Warren County

Neil C. Blumenthal, MD
Joel S. Feigin, MD

PLACEMENT FILE

The following physicians have written to the Executive Offices of MSNJ seeking information on opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

FAMILY MEDICINE

- Tariq H. Butt, MD, 605 West Madison Ave., #2606, TWR #3, Chicago, IL 60606. Dow (Pakistan) 1980. Board eligible. Group or partnership. Available July 1989.
- Eileen Hill, MD, 155 Briarwood Rd.,

Mt. Laurel, NJ 08054. Pennsylvania 1980. Board certified. Part time. Available.

- Sergiusz I. Kaftal, MD, 4114 9th Ave., Brooklyn, NY 11232. Lodz (Poland) 1981. Solo, partnership, single specialty group. Available.
- Steven Luke, MD, 111 Hicks St., 9P, Brooklyn, NY 11201. SUNY-Upstate 1982. Also, pediatrics. Board certified. Board eligible (PED). Group. Available.

GASTROENTEROLOGY

- Robert I. Leventhal, MD, 1000 J Scaife Hall Division of Gastroenterology, University of Pittsburgh, Pittsburgh, PA 15217. St. Georges (Grenada) 1984. Board eligible. Consultative, group, partnership, solo. Available July 1989.

HEMATOLOGY

- Vijaykumar Gandhi, MD, I 2126 Chapin Apts., SUNY, Stony Brook, NY 11794. Baroda (India) 1981. Also, internal medicine. Board eligible. Board certified (IM). Group, partnership, solo. Available July 1989.

INTERNAL MEDICINE

- Nancy Hsueh Beggs, MD, 242 East Second St., Atco, NJ 08004. Temple 1986. Board eligible. Group or multi-specialty practice. Available July 1989.
- Ezra Bendit, MD, 22 Mt. Rascal Rd., Hackettstown, NJ. UMDNJ 1984. Board certified. Group or partnership. Available.
- Bhuvana Chinnappan, MD, 139 Wm. Feather Dr., Voorhees, NJ 08043. Board eligible. Group, partnership, solo. Available.
- Albert S. Ford, MD, 4 Linden Lane, Scotch Plains, NJ 07076. Meharry (India) 1982. Board eligible. Solo. Available.
- Vijaykumar Gandhi, MD, I 2126

Chapin Apts., SUNY, Stony Brook, NY 11794. Baroda (India) 1981. Also, hematology/oncology. Board certified. Board eligible (HEMATOL). Group, partnership, solo. Available July 1989.

- Lalitha B. Iyer, MD, 35 Winthrop Rd., Edison, NJ 08817. Madras (India) 1980. Board eligible. Group, partnership, emergency room. Available.
- Donald Mitrane, MD, 129 Broadway, Apt. C., Huntington Station, NY 11746. Columbia 1989. Board eligible. Group or partnership. Available July 1989.

OPHTHALMOLOGY

- Lawrence Scott Halperin, MD, 5571-D Waterman, St. Louis, MO 63112. Pennsylvania 1985. Board eligible. Group practice. Available July 1991.

PEDIATRICS

- Steven Luke, MD, 111 Hicks St., 9P, Brooklyn, NY 11201. SUNY-Upstate 1982. Also, family practice. Board eligible. Board certified (FAM MED). Group. Available.

RADIOLOGY

- Robert W. Cifers, MD, 6913 Bonnie Ridge Dr., Apt. T1, Baltimore, MD 21209. Ohio State 1983. Board eligible. Also, nuclear medicine. Group, partnership, solo. Available May 1989.

SURGERY

- Robert A. Aldoroty, PhD, MD, 1270 Fifth Ave., New York, NY 10029-3417. Columbia 1984. Board eligible. Group or partnership. Available July 1989.

UROLOGY

- David S. Altman, MD, 402 Laura Dr., Danville, PA 17821. Jefferson 1985. Board eligible. Group, partnership, multispecialty. Available July 1990.

MSNJ ANNUAL MEETING

April 27-30, 1989

Sheraton, East Rutherford

AXID[®]

nizatidine

Enhances compliance and convenience

Patients appreciate Axid, 300 mg, in the Convenience Pak

In a Convenience Pak survey (N = 100)¹

- 100% said the directions on the Convenience Pak were clear and easy to understand
- 93% reported not missing any doses

Pharmacists save time – at no extra cost

- The Convenience Pak saves dispensing time and minimizes handling

The Convenience Pak promotes patient counseling

- Pharmacists dispensing the Axid Convenience Pak can encourage compliance and continued customer satisfaction



Convenience Pak is available at no extra cost



Eli Lilly and Company
Indianapolis, Indiana
46285

AXID[®]

nizatidine capsules

Brief Summary

Consult the package literature for complete information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks. Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg b.i.d. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H₂-receptor antagonists.

Precautions: General — 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.
2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests — False-positive tests for urobilinogen with Multistix[®] may occur during therapy with nizatidine.

Drug Interactions — No interactions have been observed between Axid and theophylline, chlorazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose as indicated by evidence of weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, prenatal and postnatal fertility study in rats, doses of nizatidine up to 150 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy — Teratogenic Effects — Pregnancy Category C — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers — Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

Pediatric Use — Safety and effectiveness in children have not been established.

Use in Elderly Patients — Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in domestic placebo-controlled trials, there were 11% vs 0.2% urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT or alkaline phosphatase (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS — Rare cases of reversible mental confusion have been reported.

Endocrine — Clinical pharmacology studies and controlled clinical trials showed no evidence of androgenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecostasia occurred.

Hematologic — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H₂-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumentary — Swelling and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity — As with other H₂-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H₂-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Dther — Hyperurcemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be reported.

Signs and Symptoms — There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

Treatment — To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the Physicians' Desk Reference (PDR). In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

PV 2056 AMP

[13089]

Additional information available to the profession on request.

¹ Data on file, Lilly Research Laboratories.

IN MEMORIAM

Angelo A. Barberio. We have just received notice of the death of family physician Angelo Albert Barberio, MD, in November. A 1904 New York City native, Dr. Barberio earned his medical degree at Loyola University, Chicago, Illinois, in 1930, and received his New Jersey medical license in 1940 after several years of practice in Brooklyn, New York. A fellow of the New Jersey Academy of Medicine, Dr. Barberio was affiliated with Overlook Hospital, Summit; Newark Beth Israel Medical Center; and Elizabeth General Medical Center. Active civically, Dr. Barberio served as school physician for Union High School, and as assistant township physician for Union. Dr. Barberio was a member of our Union County component and of the AMA. In 1980, he was a recipient of the Medical Society of New Jersey's Golden Merit Award for 50 years of medical practice to his community and dedication to his profession.

Winfield L. Hartman. A retired member of our Essex County component, Winfield Leinbach Hartman, MD, died on December 1, 1988. A 1910 native of Geigertown, Pennsylvania, Dr. Hartman earned his medical degree at Temple University School of Medicine, Philadelphia, Pennsylvania, in 1937. After obtaining a New Jersey medical license the following year, Dr. Hartman opened a family practice in South Orange. He also was on the staff of the Hospital Center at Orange and St. Mary Hospital, also in Orange. Dr. Hartman was a member of the

Academy of Medicine of Northern New Jersey and of the AMA. During World War II, he served as a lieutenant colonel in the United States Army medical corps. He received the Medical Society of New Jersey's Golden Merit Award in 1987.

Sadanand B. Joshi. Pediatrician Sadanand Balwant Joshi, MD, died on November 30, 1988. A 1939 native of Bharwar, India, Dr. Joshi received his medical degree in 1963 at Karnatak Medical College, Hubli, India, before emigrating to the United States; he was awarded his New Jersey medical license in 1972. Dr. Joshi served on the staff of Shore Memorial Hospital, Somers Point, as a pediatrician. A diplomate in pediatrics and a fellow of the American Academy of Pediatrics, Dr. Joshi was a member of our Atlantic County component.

Edward M. Lance. Specialist in thoracic and vascular surgery, Edward Merriman Lance, MD, died on November 16, 1988, at the age of 62. Born in Rahway, Dr. Lance attended Johns Hopkins University School of Medicine, Baltimore, Maryland, receiving his medical degree in 1951. Dr. Lance had further training in general and thoracic surgery at Vanderbilt University, Nashville, Tennessee. As well as maintaining a private practice in Neptune City, Dr. Lance was a surgeon at Jersey Shore Medical Center for 28 years. A diplomate in surgery and thoracic surgery, Dr. Lance was a fellow of the American College of Surgeons, and a member of our

Monmouth County component, and of the AMA. Dr. Lance was affiliated with Monmouth Medical Center, Long Branch, and served as president of the New Jersey State Society of Surgeons. During the 1950s, Dr. Lance served as a lieutenant in the U.S. Navy. In 1976, Dr. Lance received the Medical Society of New Jersey's Golden Merit Award for 50 years of medical practice in his community.

J. Krevin Leir. Notice was just received of the death of Jacob Krevin Leir, MD, a retired member of our Ocean County component. Born in 1900 in Charleston, South Carolina, Dr. Leir was graduated from the Medical College of South Carolina in 1930. A specialist in internal medicine and rheumatology, Dr. Leir was licensed to practice in New Jersey in 1931. In addition to maintaining a private practice, Dr. Leir was affiliated with Jersey City Medical Center. He was a member of the New Jersey Rheumatism Association and of the American Medical Association.

Zenaida A. Magalindan. Obstetrician-gynecologist Zenaida Abadam Magalindan, MD, died on October 29, 1988, after years of private practice in Newark and Piscataway. Born in the Philippines in 1944, Dr. Magalindan received her medical degree from Far Eastern University, Manila, Philippines, in 1968, and emigrated to the United States soon afterward. A member of our Middlesex County component, Dr. Magalindan served on the staff of Saint

Michael's Medical Center, Newark, and Rahway Hospital, as well as maintaining her private practices in Essex and Middlesex counties.

Edwin N. Murray. A retired member of our Camden County component, cardiologist Edwin Nelson Murray, MD, died on October 29, 1988, in Falls Church, Virginia. A 1909 Pocomoke, Maryland native, Dr. Murray attended Jefferson Medical College of Philadelphia, Pennsylvania, and was awarded his medical degree in 1933. Obtaining his license to practice in New Jersey a year later, Dr. Murray became affiliated with Cooper Hospital/University Medical Center, Camden, and Zurbrugg Memorial Hospital, Riverside. He served the United States Army during World War II as a lieutenant colonel. A diplomate in cardiovascular disease and a fellow of the American College of Physicians, Dr. Murray received the Medical Society of New Jersey's Golden Merit Award in 1983, for 50 years of medical practice to his community.

Carl C. Pfeiffer. A founder of the Princeton Brain Bio Center, Skillman, Carl Curt Pfeiffer, MD, died on November 18, 1988, at the age of 80. A native of Peoria, Illinois, Dr. Pfeiffer received his medical degree at the Chicago College of Medicine and Surgery, Illinois, in 1937, specializing in clinical pharmacology and nutrition, with an emphasis on the psychiatric disorder, schizophrenia. Dr. Pfeiffer was chairman of the Pharmacology Department at the University of Illinois (1943-1945), director of the Division of Basic Health Sciences of Emory University Medical School (1957), and deputy director of the Bureau of Research and director of research in neuropharmacology at the New Jersey Neuropsychiatric Institute. After the Bureau of Research at

the New Jersey Psychiatric Institute in Montgomery was disbanded, Dr. Pfeiffer started the Princeton Brain Bio Center in 1973. The author of more than 250 articles on schizophrenia, Dr. Pfeiffer was a member of many scientific organizations, including: the American Society of Pharmacology and Experimental Therapeutics; the American Society for Experimental Biology and Medicine; the American Association for the Advancement of Science; the Medicinal Division, American Chemical Society; the New York Academy of Science; the American Academy of Neurology; the Association for Research in Nervous and Mental Disease; the Canadian Pharmacology Society; the Society for Biological Psychiatry; the American Therapeutic Society; the AMA; and our Mercer County component. For his years of service, Dr. Pfeiffer received many honors and awards: the R.B. Allen Teaching Award from the University of Illinois in 1959; Certificate of Merit from the University of Chicago in 1954; pharmacology specialist for the U.S. Public Health Study Section; vice-president of the Illinois Society for Medical Research; and treasurer of the Brain Research Foundation. In 1987, Dr. Pfeiffer received the Medical Society of New Jersey's Golden Merit Award.

Victor M. Ruby. Victor M. Ruby, MD, a semiretired resort physician, died on November 2, 1988, at the age of 68. Born in 1920 in Ohio, Dr. Ruby earned his medical degree from Jefferson Medical College, Philadelphia, in 1945. He served as a captain in the U.S. army from 1946 to 1948. Dr. Ruby, also known as Victor Travis, conducted the classical music show, "Concert Hall," on Sunday evenings; he was honored in April 1988 for his 2,000th broadcast. Also, Dr. Ruby participated in a weekly radio show, "Your Doctor Speaks,"

a public service program. During his medical career, Dr. Ruby was affiliated with the Atlantic City Medical Center; he was a member of our Atlantic County component and of the American Medical Association. Dr. Ruby was a past president of the American Heart Association and a fellow of the American College of Chest Physicians. In 1986, Dr. Ruby received the Cooper Foundation Health Care Professional Award.

Joseph John Speranza. A retired member of our Bergen County component, family physician Joseph John Speranza, MD, died on October 21, 1988, at the age of 79. A Brooklyn, New York native, Dr. Speranza received his medical degree at the University of Bologna, Italy in 1936, and was awarded his New Jersey medical license in 1943. A general practitioner with a private practice, Dr. Speranza was affiliated with Bergen Pines County Hospital, Paramus, and the Valley Hospital, Ridgewood. He was a captain in the U.S. Army medical corps during World War II. A fellow of the American Occupational Medicine Association, Dr. Speranza was a member of the AMA. For his 50 years in service, Dr. Speranza received MSNJ's Golden Merit Award in 1986.

Irene S. Terlecky. Edison family physician Irene Stephania Terlecky, MD, died on November 29, 1988, after retiring in 1987. A 1921 native of the Ukraine, Dr. Terlecky received her medical degree at Ludwig Maximilian University, Munich, Germany, in 1949, before emigrating to the United States. Licensed to practice in New Jersey in 1961, Dr. Terlecky was on the staff of East Orange Veterans Hospital for 2 years, followed by 13 years as a staff member of Roosevelt Hospital, Edison. She was a member of our Essex County component and of the AMA.

Let's Work Together

The practice of medicine has gone through a period of unprecedented accomplishments since the 1940's. Life expectancy continues to lengthen and the quality of life continues to improve. There is more that remains to be done. We must all stand together — physicians and patients to find

solutions to the problems that remain. We must solve the problems of providing adequate physical and mental health services and long term out of the hospital care for our aging population. From early civilization, service to mankind has been the leading principle of medical practice.

Physicians devote considerable time and effort without seeking recognition or reward. Sixty-eight percent of primary care physicians voluntarily give time at free clinics, nursing homes and other social service health care facilities. One-third of the care given by emergency physicians is donated. Most New Jersey physicians are cooperating in the Voluntary Medicare Assignment Program. The Medical Society of New Jersey, with the cooperation of the county medical societies, is working in conjunction with the Office on Aging and the Senior Citizen Council to provide a Senior Medical Courtesy Program. Contact your county medical society for further information. Every day in the



USA, four million patients interact with physicians giving the medical profession an opportunity to demonstrate their competence, caring and devotion to each patient they serve.

Hopefully major issues such as Medicare, drug abuse, professional liability, AIDS, and the ration-

ing of health care will be addressed in the public forum. It is there that the public and the medical profession can meet in a non-adversarial role to plan the future of medical care that will confront the issues of today rather than confound them with non-productive political windstorms filled with empty promises. Bureaucratic fiat and controls will not insure quality care.

The American medical system is truly one of our country's greatest treasures. Beware of changes that make it difficult if not impossible to protect the quality of care patients deserve and expect.

The medical profession has been requesting Medicare reform and the public should also urge Congress to honestly address the need for Medicare reform.



Your County Medical Society and
**The Medical Society
of New Jersey**

2 PRINCESS RD., LAWRENCEVILLE, N.J. 08648

EDITORIAL CRITERIA

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. All material published is copyrighted by MSNJ.

Content. The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevant to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made to an audience in New Jersey.

Assignment of Copyright. In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statement accompany-

ing material offered to *NEW JERSEY MEDICINE* must contain the following language and must be signed by all authors.

"In consideration of *NEW JERSEY MEDICINE* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *NEW JERSEY MEDICINE*.

Specifications. Submit two manuscripts that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods should be identified.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 30-word abstract.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission must be submitted.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—[®].

References should not exceed 35 citations except in review articles, and should be cited consecutively by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in numerical order. The style of *NEW JERSEY MEDICINE* is that of *Index Medicus*:

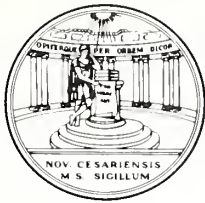
1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

Publication Policy. Receipt of each manuscript will be acknowledged; the paper will be referred to the Editorial Board. The final decision is reserved for the editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. Galley proofs will be submitted to the author for correction.

Reprint Orders. Reprints may be ordered after the author is notified that the article has been selected for a specific issue. A check for the cost of reprints must accompany that order.

Communications. All communications should be sent to the editor, *NEW JERSEY MEDICINE*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.



MSNJ NEWSLETTER

MEMBERSHIP DIRECTORY

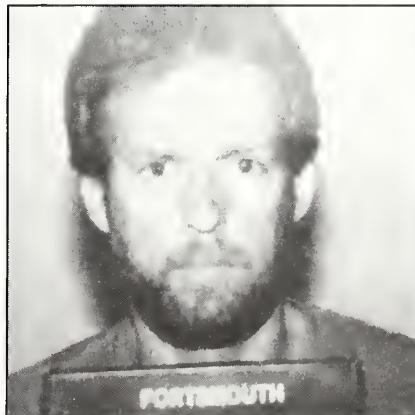
The *Membership Directory* for the Medical Society of New Jersey is available. All members of the Society have received a copy. For additional copies, send \$65 plus \$3.90 sales tax (except for tax-exempt companies) to Mrs. Joyce Guest, MSNJ, Two Princess Road, Lawrenceville, NJ 08648. If you need additional information, please call 609/896-1766.

AMBULATORY MEDICAL CARE SURVEY

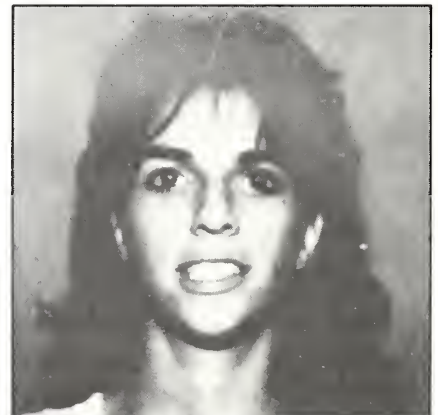
The National Center for Health Statistics, as part of its continuing program to provide information on the health status of the American people, is conducting the National Ambulatory Medical Care Survey (NAMCS). The purpose of this study is to collect information about ambulatory patients, their problems, and the resources used for their care. The resulting published statistics will help plan for more effective health services, determine health manpower requirements, and improve medical education. Since practicing physicians are the only reliable source of this information, we need your assistance in the NAMCS. Physicians selected in the national sample are essential to the success of the study. The NAMCS is authorized by Title 42, United States Code, Section 242k. Participation is voluntary. Although there are no penalties for not participating, each nonresponse makes the national statistics less accurate. All information collected is held in strict confidence, and will be used only to prepare statistical summaries. Many organizations and leaders in the medical profession have expressed their support for this study. Within a few days, a representative of the Census Bureau, acting as our agent, will telephone you for an appointment to discuss the details of participation.

OB/GYN ALERT FOR FUGITIVE'S WIFE

The Federal Bureau of Investigation is seeking information regarding Robert Charles Witt or his wife, Elizabeth Dunn Witt. Mrs. Witt is pregnant, with serious medical problems. Robert Witt, a fugitive from Virginia, is noted to be armed and dangerous with extreme escape risk. If you have any information on Robert or Elizabeth Witt, please call the FBI, 609/883-4499; refer to file 88B-6760.



Robert Witt



Elizabeth Witt



CAPITOL COMMENTARY

MEDICAL EXAMINER REVAMP

Despite outspoken opposition from the Attorney General's office, a Senate Committee is poised to release a major bill to reform how the State Board of Medical Examiners (SBME) acts on complaints. S-2936, sponsored by Senator Richard J. Codey (D-West Orange), would establish a medical practitioner review panel to investigate complaints against physicians, podiatrists, and chiropractors. The nine-member panel would refer complaints to SBME when it finds that disciplinary action is warranted.

Creation of the new panel was suggested by the Society in response to the State Commission of Investigation's 1987 report on impaired and incompetent physicians. The SCI accused physicians and hospitals of engaging in a "conspiracy of silence" by not reporting physicians who are incompetent or impaired by alcohol, drug abuse, or a mental or physical disability.

Despite the state's objections that the review panel would be a "new layer of bureaucracy" which would impede the Board's disciplinary activities, it is apparent that this major reform will remain intact when the committee meets to release the bill next month. Throughout the April 13 hearing, the Society's special counsel, former judge Herbert J. Stern, repeatedly stressed that the panel not only would be able to review complaints more expeditiously, but also would establish legal protections which the state should—but does not—give to physicians today.

Although the bill was introduced last September, the SCI waited until two days before the hearing to submit its comments to Senator Codey. Incredibly, one of its major recommendations is a law which would permit the use of electronic eavesdropping and wiretapping against physicians, without a court order. Senator Codey firmly rejected the idea.

PIP SCHEDULE PUBLISHED

The State Insurance Department has proposed a voluminous schedule of reimbursement rates for patients whose injuries are covered by automobile insurance. The schedule results from passage last year of legislation which "reformed" New Jersey's auto insurance law. In an attempt to reduce premiums, the law now requires an accident victim to pay the first \$250 of his physician and hospital expenses, and limits the amount of benefits for which auto insurance carriers are responsible. For this reduced coverage, the insurance department estimates that a policyholder will receive at best a \$20 annual reduction in premium.

According to published reports, Insurance Commissioner Kenneth Merin has asked the attorney general to investigate whether the new law gives him the authority to prohibit physicians from balance billing. The Society is certain that the law invests no such power in the commissioner. The larger question, however, is whether the Department's proposed reimbursement schedule is reasonable. The Society has asked every specialty group to carefully review this material and recommend necessary adjustments.



PROFESSIONAL LIABILITY

COURT WILL NOT ORDER AIDS TESTS

The Supreme Judicial Court of Massachusetts has reversed a lower court order that a school for the mentally retarded conduct AIDS tests on residents who were allegedly sexual partners. The State Department of Mental Health had obtained a "permanent limited guardian" over one of its charges, a moderately retarded man. Subsequently, the Department moved to modify his medical treatment plan in order to remove a venereal wart. By the date of the hearing, the wart had disappeared and the Department moved to dismiss its motion. The judge nevertheless inquired into the man's medical history and sexual activity, and the threat of AIDS and venereal disease.

Finding that there were no restraints placed on the sexual activities of residents of the state school where the man resided, and over the objections of the man's attorney, physician, and guardian, the trial judge ordered the school to conduct AIDS tests on the man and his sexual partner. The Mental Health Department appealed and the Supreme Judicial Court took the case on its own motion. Finding that the order resulted from the trial judge's perception of a threat to the health of the residents of the school and not solely from the concern for the welfare of the individual resident, the high court found that the order was not within the trial court's guardianship jurisdiction. Furthermore, there were no findings and nothing in the record to support a conclusion that testing this individual for AIDS either is appropriate or necessary to meet the needs of the residents. The judge's order was an inappropriate intrusion on the executive and legislative "territories," the court found. The court vacated the trial court's order and remanded the case for "such further guardianship proceedings as may be appropriate." (**Reprinted from *The Citation* with permission, American Medical Association, 535 N. Dearborn Street, Chicago, IL 60610, October 1, 1988, Volume 57, Number 12**)

THE FLOW OF NEW DRUGS

Costly product liability suits are retarding the development and sale of new potentially lifesaving medical products, warned the American Medical Association at an American Tort Reform Association press conference in Washington last month. Many small companies conducting innovative research on new drugs are delaying or foregoing the release of such products because of the increased costs of litigation and insurance—costs which sometimes exceed any projected profits, the AMA said. Basic biomedical research has deteriorated in such fields as contraception as well. With compounded annual rates of +17 percent and jury awards climbing to +\$1.8 million from \$494,580 between 1974 and 1985, creative solutions are needed, the AMA said. (***Medical Liability Monitor*, December 21, 1988, Volume 13, Number 11**)

SECOND THOUGHTS ON IUD AWARD

Citing errors of evidence, G.D. Searle & Co., Skokie, Illinois, maker of the Copper-7 intrauterine device, is seeking reversal of an \$8.75 million award to a Minnesota woman who alleges the IUD caused infertility. Searle, which stopped making the IUD in 1986 due to mounting lawsuits,

is petitioning for a new trial in St. Paul on the basis of affidavits filed by three jurors who told a federal district judge they wanted to rescind their verdict. Indicating "continual verbal harassment and intimidation" during jury deliberations, the jurors said while Searle may have been negligent in its advertising of the IUD, they were not convinced the plaintiff had been injured by it. Of 1,300 such suits filed against Searle, so far the company has won 15 of 19. (*Medical Liability Monitor*, December 21, 1988, Volume 13, Number 11)

HUMAN BITE IS A DEADLY WEAPON

A prisoner's AIDS condition was not relevant to a determination of whether he was properly convicted of assault with a deadly weapon by biting correctional officers, a federal appellate court for Minnesota ruled. The prisoner had tested positive for antibodies for the human immunodeficiency virus (HIV), and was an inmate at the federal medical center. Approximately one month later, during a struggle over his smoking in a nonsmoking area, he bit two corrections officers, holding his mouth over the bitten areas for several seconds. Thereafter, he told a nurse that he "wanted to kill" the officers and hoped "that they get the disease" that he had.

He was indicted on and convicted of two counts of assault with a deadly and dangerous weapon, i.e. his mouth and teeth, and was sentenced to five years in prison, to run consecutively to the sentence he was serving at the time of the incident. On appeal, the federal appellate court upheld the conviction, saying that a deadly and dangerous weapon need not be inherently dangerous, or a weapon such as a gun or knife. What matters is not the nature of the weapon, but its capacity, given the manner of its use, to endanger life or inflict great bodily harm. The prisoner contended that proof of the dangerousness of his bites was lacking, since the prosecution could not establish that AIDS can be transmitted by biting. The court rejected his contention on two grounds.

First, it is not necessary that the deadly and dangerous weapon as used by the defendant actually causes bodily harm, so long as it has the capacity to do so in the way it was used. Second, there was sufficient evidence to allow the jury to find that the mouth and teeth were a deadly and dangerous weapon, even if the defendants were not infected with AIDS.

The court emphasized that the medical evidence in this case was insufficient to establish that AIDS may be transmitted by a bite. It was sufficient to establish that the prisoner's mouth and teeth were a deadly and dangerous weapon, regardless of the presence or absence of AIDS.

Editor's Note: The court does not distinguish in this case between a finding of positive for HIV antibodies and a diagnosis of AIDS. Nothing in the report of the case indicates the prisoner was diagnosed as having AIDS, although the language of the opinion certainly implies that this is the case. (Reprinted from *The Citation* with permission, American Medical Association, 535 N. Dearborn Street, Chicago, IL 60610, October 15, 1988, Volume 58, Number 1)

PROTECTION FOR AIDS VACCINE SUITS

"Protect us from AIDS vaccine suits," drugmakers warn, or promising new drugs will not be introduced to treat the deadly disease because of liability fears. Vaccines draw more suits than other drugs, and insurance is costly. Companies want suit immunity and a government claims payment like the one set up for swine flu vaccine. (*Medical Liability Monitor*, December 21, 1988, Volume 13, Number 11)



PRESIDENT'S PAGE

MALPRACTICE SURCHARGE

At its March 19, 1989, meeting, the Board of Trustees reviewed a copy of the response of Special Counsel, Judge Herbert J. Stern, to Hearing Officer Bakke's report to the commissioner of insurance regarding the proposed medical malpractice surcharge ruling. In a brief summary of the Society's view, Judge Stern commented that while the Bakke report recognizes the inequity of the rule as originally proposed, its attempt to resolve this inequity is itself unfair, and is not supported by statutory authority. Judge Stern referred to a statutory procedure which is within the purview of the commissioner that could be implemented in addressing the need to assist the insolvent Reinsurance Association. The utilization of this statutory solution was urged.

MEDICARE/ICD-9 CODES

Physicians now are expected to correlate ICD-9 codes with CPT-4 billings for Part B. This cross-referencing will be mandatory by June 1, 1989. Pennsylvania Blue Shield will be mailing an advisory to New Jersey physicians within several weeks (page 410).

MSNJ VERSUS OMBUDSMAN

The Medical Society of New Jersey has entered the suit challenging the ombudsman's August 1988 letter to nursing home administrators. The Society believes the ombudsman letter lacks lawful authority. The case has been transferred to the Appellate Division. MSNJ is moving for expedited review before the Supreme Court. Concurrently, the Department of Health has proposed regulations regarding "Freedom of Choice of Nursing Home Residents." They are a responsible but not ideal answer to the problem created by the ombudsman's letter. MSNJ will offer comments in the rule-making procedure. In the interim, physicians are advised that MSNJ counsel believes that adherence to the Department of Health proposals is a prudent course for physicians to follow.

MEDICARE TRANSITION

There are multiple problems as a result of the transition from Prudential to Pennsylvania Blue Shield as the Part B carrier. Some physicians have received no payments at all, others have received only about 20 percent of the claims processed; and MAACs for hundreds of physicians have been improperly calculated or "lost." Additionally, carrier policy regarding global fees and assisting surgeons was unilaterally and unfairly altered. On March 1, 1989, at my request, staff met with PBS officials and the HCFA officials in charge of the Philadelphia office. A procedure was agreed on to correct errors, and the policy matters were taken under reconsideration review. On March 21, 1989, our staff advised HCFA that the progress hoped for was not occurring. HCFA has increased its intervention and surveillance. We also have been advised that the policy matters being reconsidered should be favorably resolved by the end of March.

FINI

I want to thank all of you who made this year both pleasant and interesting for me. It has passed quickly. Much has occurred, and as you can see, we have met the challenges head-on.



EDITOR'S DESK

CLEOPATRA'S NEEDLE

Cleopatra's needle on the bank of the Thames is more than an Egyptian relic dedicated to a beautiful queen. It also is a monument to the coming-of-age of dermatology as a specialty. Although the obelisk had been presented to the British nation in 1820, it took the beneficence of Sir Erasmus Wilson to have it transported to London, where it was erected in 1878.

William James Erasmus Wilson (1809-1884), who helped pay for the transport of the cenotaph, limited his practice to dermatology after 1840 and established dermatology as a true specialty, at least in the eyes of the public, by his instructive book, *Healthy Skin*, published in 1845. He also wrote the more scientific *Diseases of the Skin* and was the editor of the first dermatology journal. Although Wilson was the first to fix dermatology as a discipline worthy of its own name, part of, and yet separate from, the whole body of medicine, his was only one landmark in the history of his calling. Prehistoric man recognized and treated some conditions of the skin. The Sumerians wrote the first prescriptions; the Egyptians enlarged the pharmacopoeia. Hippocrates expanded the breadth of knowledge and added "alopecia" and "pityriasis" to our language. He also recognized that dermatologic problems could arise from both internal and external stimuli. Celsus, Galen, Arabian, French, and Spanish physicians all added to the study.

The first dermatologic text, *De Morbis Cutaneis*, was published by Gerolamo Mercuriale in Padua in 1571. Daniel Turner published a book by the same name in English in 1714. Robert Willan wrote *On Cutaneous Diseases*, issued from 1798 to 1808—the first modern categorization and analysis of skin diseases, accompanied by marvelous handpainted prints.

Jean Louis Alibert, a French physician at the Hôpital S. Louis in Paris, published three massive volumes from 1806 to 1832, complete with hand-painted prints, classifications, and descriptions. Dr. Alibert established the first dermatology teaching center.

And, in 1841, Ferdinand von Hebra (1816-1880), a Vienna dermatologist, was segregated to the "rash room" in the Allgemeine Krankenhaus. Hebra's clinic became a renowned center because of his demonstrations and classifications that included the distribution of lesions.

The last part of the 19th century brought dermatology into the modern era with the application of basic sciences. Bacteriologic insights were gained by the works of Pasteur, Kochard, and Schaudinn. The microtome was developed in the 1870s and the word "biopsy" coined by the French as a result. Paul Gerson Unna, of Unna boot fame, almost singlehandedly laid the foundation for dermatopathology with his two texts, *Histopathologic der kauterkrankheiten* (1894) and *Biochemic der haut* (1913.)

The 20th century has seen the same explosion of knowledge in dermatology as in the rest of medicine. Advance has piled upon advance,

in testing, diagnosis, and treating. The engineer, pharmacist, chemist, geneticist, pathologist, microbiologist, radiologist, allergist, and others in the medical profession are all contributing to the growth in the dermatologic sphere. There were 100 recognized skin diseases in 1800; today there are over 1,000.

Thus, this special issue of *NEW JERSEY MEDICINE* can but scratch the epidermis of the subject. We should note, for example, that neither this issue nor the November 1988 journal on occupational and environmental health has dwelt on the huge impact, both personal and economic, of occupational skin disorders, including dermatoses, responsible for at least one-third of job-related illnesses.

But the papers herein clearly demonstrate the increasing importance of this discipline; it is not merely "cosmetic" in nature, despite the reams of publicity touting minoxidil and Retin-A[®], for this purpose. We are indebted to Dr. Christopher Papa and his colleagues.

On behalf of *NEW JERSEY MEDICINE*, I would like to thank the following companies for supporting this issue. Without their commitment to medical education, specifically in the field of dermatology, we would not have been able to publish this four-color, expanded special issue. We thank:

American Cyanamid Company
American Dermal Corporation
Dermik Laboratories, Inc.
Glaxo Dermatology Products
Neutrogena Skin Care Institute
Ortho Pharmaceutical Corporation
Stiefel Foundation for Dermatological Research, Inc.
Westwood Pharmaceuticals

Now that summer is nigh and the sunning season is upon us, perhaps we should remember that tanning ultimately ages the skin prematurely, and that there is no fountain of youth. As Horace (Odes, Book II, Ode XIV) noted:

*Postumus, Postumus, the years glide by us,
Alas! no piety delays the wrinkles,
Nor old age imminent,
Nor the indomitable hand of Death,
Whether that earth we ruled
As kings, or served as drudges of its soil.*

LETTERS TO THE EDITOR

Letters to the editor are welcome. All correspondence will be subject to editing and will be used as space permits. Authors are asked to seek clarity, accuracy, and originality. We will acknowledge all letters. Communications should be sent to *NEW JERSEY MEDICINE*, Two Princess Road, Lawrenceville, NJ 08648.

RARE BOOK DISPLAY

An exhibition of rare medical textbooks that graphically trace the study of the heart from the 16th century is on display at the Newark campus of the University of Medicine and Dentistry of New Jersey (UMDNJ). The exhibit features a dozen historic texts and some early medical equipment used to diagnose heart disease.

The exhibit, which is free and open to the public, is located in the gallery of the Smith Library. Open 9 A.M. to 5 P.M. daily, except holidays, the textbooks will be shown through December 1989. Further information is available by calling 201/456-4580.

WE CAN MAKE YOUR LIFE EASIER

with practice management services by

Rosewood Medical Management

- Improve accounts receivable
- Decrease billing problems and complaints
- Always courteous to your patients when they call
- Improve diagnosis and procedure coding accuracy
- Optimize third party reimbursements
- Electronic claim submission:
Blue Shield of New Jersey
Medicare

All specialties

For further information, contact Valerie Wood



Rosewood

MEDICAL MANAGEMENT, INC.

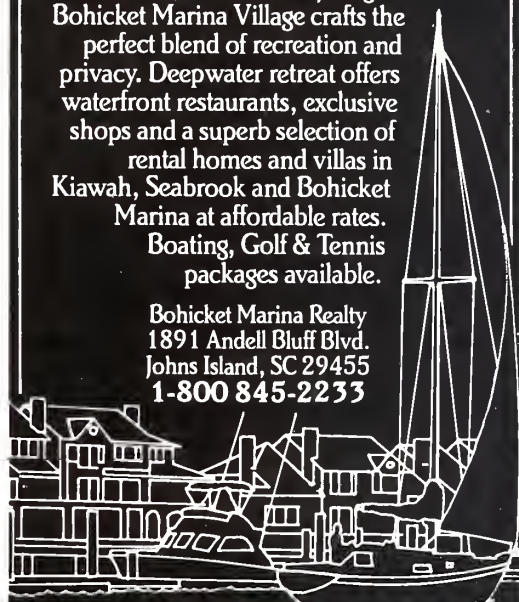
27 MECHANIC STREET
RED BANK, NJ 07701
(201) 576-8100

WATER WORKS!

FOR THE DISCRIMINATING
VACATIONER WHO LOVES IT!

Between the gates of Kiawah & Seabrook, uncommonly elegant Bohicket Marina Village crafts the perfect blend of recreation and privacy. Deepwater retreat offers waterfront restaurants, exclusive shops and a superb selection of rental homes and villas in Kiawah, Seabrook and Bohicket Marina at affordable rates. Boating, Golf & Tennis packages available.

Bohicket Marina Realty
1891 Andell Bluff Blvd.
Johns Island, SC 29455
1-800 845-2233



COMPLIMENTARY CRUISE FOR 2,
ONE WEEK OR LONGER RENTAL.
(MEMORIAL DAY THRU LABOR DAY)

Medicalstructures*

DESIGNERS-ARCHITECTS-BUILDERS

NEW JERSEY'S FOREMOST
BUILDERS OF WALK-IN
MEDICAL FACILITIES & OFFICES
COMPLETE DESIGN,
ARCHITECTURE & FINISHED
CONSTRUCTION IN A SINGLE
WORRY-FREE PACKAGE.

FOR FURTHER INFORMATION
AND REFERENCES—PHONE
TOLL FREE

1-800-325-2160

* A DIVISION OF

J.S. HARPER CO.

2430 E. LINDEN AVE.
LINDEN, N.J. 07036

R JUST WHAT THE DOCTORS ORDERED!

- Allergists
- Cardiologists
- Dermatologists
- ENTs
- GPs/FPs
- Imaging Centers
- Internists
- OB/GYNs
- Ophthalmologists
- Orthopedic Surgeons
- Pediatricians
- Plastic Surgeons
- Psychiatrists
- Sports Medicine Centers

Over 100 physicians in a wide range of specialties have prescribed the same treatment for their practices—the medical marketing services of PHYLLIS KESSEL ASSOCIATES. Our proven record of success has made us New Jersey's leading medical public relations and advertising firm. If you are concerned about maintaining or improving the health of your practice, call us today for a confidential consultation.

(201) 531-7080



phyllis kessel associates
780 west park avenue
oakhurst, NJ 07755



BOOK REVIEWS

THE CORNEA: WORLD CONGRESS

H. Dwight Cavanagh. New York, NY, Raven Press, 1988. This book contains 108 papers presented at the World Congress on the Cornea III. The text is divided into ten sections, covering topics from basic research in the specified area to new techniques and treatment modalities. The first section contains 12 articles on the tear film and ocular surface. The next section is on corneal hydration and clarity and deals predominately with the use of various tissue storage mediums and their effects on the corneal endothelium. There also are two articles dealing with the use of irrigation solutions in intraocular surgery. The section on cornea and systemic diseases contains six articles on the topic including one on the eye in immunodeficiency disorders. The next section is on the biophysical aspects of the cornea. This section encompasses 18 articles which cover a variety of topics from the interaction of light and the cornea to the development of an artificial cornea. The section on contact lenses and the cornea contains 11 articles covering such topics as the corneal changes seen after fitting aphakic infants and young children to the epidemiology of infections related to contact lenses. There also are several articles related to rigid gas permeable materials. The section on surgery of the cornea contains 13 articles covering topics from the artificial cornea to an evolution of corneal scarring and treatment of corneal stromal vascularization with the argon laser. The section on corneal immunology deals with the donor and recipient mismatching and manipulations to prevent graft rejection. There also are several articles on herpetic keratitis. A short section on dystrophies and degenerations is represented by 3 articles. Antimicrobial agents take up another section containing 14 articles. Such topics as trachoma, herpes simplex, and *Acanthamoeba* keratitis are covered. Finally, there is a section on refractive corneal surgery which covers radial keratotomy, keratomileusis, laser-ablation surgery, and epikeratophakia. The editor has done a nice job of assembling the presentations and categorizing them to provide an up-to-date summary of the advances in the area of cornea and external diseases. ■ William H. Constad, MD

CT WITH MRI CORRELATION

Joseph K.T. Lee, MD, Stuart S. Sagel, MD, Robert J. Stanley, MD. New York, NY, Raven Press, 1989. This timely and updated second edition brings magnetic resonance imaging (MRI) face to face with computed tomography (CT) technology. The first edition, published in 1982, was devoted to computed body tomography. With the second edition, CT technology was refined and accepted as routine clinical procedure, while MRI technology evolved from the stage of research and development to the clinical arena.

Thirty-eight contributors and three editors undertook this mammoth work which spans 25 chapters and 1,168 pages. The book covers a concise review of the physics and instrumentation of CT and MRI, practical technical data for both modalities including detailed step-by-step protocols for imaging different anatomical regions, outline of applied

interventional CT, and detailed description of the imaging of the extracranial organs of the body in health (normal anatomy) and disease. A special chapter is devoted to pediatric applications and another to the use of CT and MRI in radiation therapy treatment planning. The final chapter is thoughtfully devoted to the history, economics, and politics of CT and MRI. It provides the radiologist with the needed ammunition to convince the hospital administrator with the clinical values and cost effectiveness of CT and MRI, and supplies the arguments required by certificate of need applicants.

The book is well written and profusely illustrated with diagrams and photographs of CT and MRI images of well-selected cases, accompanied by adequate labeling and detailed legends. The quality of paper and printing is excellent. For the price of \$140, the book is a bargain to the radiologist, and a good investment for the radiology resident, the non-radiologist specialist, and the oncology specialist. For a medical library, it is a must. ■ Ismail Kazem, MD

HEPATIC AND BILIARY CANCER

Harold J. Wanebo. New York, NY, Marcel Dekker, Inc., 1987. A remarkably comprehensive review, this ambitious text deserves attention for several reasons: it collates within a single cover virtually all of the known clinical information pertaining to hepatobiliary malignancies; whereas these cancers are relatively uncommon in the United States, hepatoma remains one of the most common worldwide; and new insight into epidemiology and etiology as well as current and future management innovations portend greater importance for these disorders.

Forty-three international experts have collaborated under Dr. Wanebo's able editorial direction to provide us with a thorough exploration of the scientific and clinical intricacies of cancers of the liver, biliary ducts, and gallbladder. Ranging from anatomic considerations through radiologic diagnostic techniques, to therapeutic considerations, the book is analytical and insightful, if not a little formidable.

This book is the eighth from this publisher in a series entitled "Science and the Practice of Surgery." It is intended for all oncologists, and may be of interest to gastroenterologists, pathologists, radiologists, and investigators in this field of biotechnology. ■ Alan J. Lippman, MD

PSYCHIATRY AND APPLIED MENTAL HEALTH

Daniel Z. Freeman, MD. Chicago, IL, Year Book Medical Publishers Inc., 1988. This is one of 35 Year Books in a variety of fields from anesthesia to vascular surgery. The Year Book of Psychiatry and Mental Health has been appearing annually for two decades and provides abstracts and critical comments on articles from a large number of journals. In the 1988 volume, 113 journals are represented. Some of these journals are seen by most psychiatrists, some by few, and others perhaps only by the editors of the Year Book.

The book is arranged in 16 chapters, each covering a different area of subject matter; the areas most represented are community psychiatry, biologic psychiatry, psychopharmacology, and child and adolescent mental health. These chapters are edited by John Talbott, Herbert Meltzer, Daniel X. Freedman, and Reginald Lourie, respectively. The fifth editor, equally eminent and capable, is Herbert Weiner, who edits chapters on psychosomatic medicine (a field in which he has been a leading investigator for many years), clinical psychiatry, alcoholism, and geriatric psychiatry. There are excellent subject and author indexes, and very few typographical errors. This text should be in every medical library and will prove very useful as a ready source of recent publications in psychiatry and mental health. ■ A. Arthur Sugarman, MD

Skin Cancer in New Jersey:

Skin Sense

*"The flowers that bloom in the spring,
Tra la,
Breathe promise of merry sunshine."**

With the advent of the season of renewal, the human species stirs with the rest of the animal kingdom, eager to shake off the grey winter, to get ready, to preen, to display. As time progresses from equinox to equinox, more and more bare skin meets the not-so-merry sun, and over the years, ultraviolet exposures mount. The results are the unpleasant alterations which signal "aging" and, for a goodly part of the populace, a variety of skin cancers. There is reason to believe that such changes are not inevitable, that they can be prevented, ameliorated, and treated. That message has been the central theme of the Melanoma/Skin Cancer Detection and Prevention Program mounted annually by members of the Dermatological Society of New Jersey. As the yearly campaign times its activities when they will do the most good, each spring, so this special issue of *NEW JERSEY MEDICINE* coincides with the fifth anniversary of the program.

I would like to thank the following companies for their support of this project. Without the commitment to dermatologic education, this special edition would not have been published; the generous financial contributions allowed for a full-color issue and an extra printing of the journal for greater circulation. On behalf of the staff of *NEW JERSEY MEDICINE* and the Committee on Publication of the Medical Society of New Jersey, I extend my thanks to: American Cyanamid Company; American Dermal Corporation; Dermik Laboratories, Inc.; Glaxo Dermatology Products; Neutrogena Skin Care Institute; Ortho Pharmaceutical Corporation; Stiefel Foundation for Dermatological Research, Inc.; and Westwood Pharmaceuticals, Inc.

Why have close to 10,000 people been screened for skin cancer in the past four years? Why has the free examination program been successful? A major part of the explanation is that many of our patients have a passing familiarity

with the "signs of cancer." Those who come to the screenings bring a worrisome lesion that either is dark, or changing color, enlarging, bleeding, or simply persisting. The patients want a competent, clear opinion about what it is, and what to do about it. The greater number will only need an explanation and reassurance; however, one in four patients will have precancerous or malignant lesions requiring further treatment. These are odds which make skin scanning a worthwhile endeavor. Would that physicians could render formal programs unnecessary by looking carefully at every patient.

Of course, taking a real good peek at skin has other rewards. Patients are impressed with such thoroughness and delighted to know the doctor cares about how they look, not only how they feel. A physician also may detect the external signs of some lurking internal illness and perhaps provide lifesaving, timely intervention. Articles in this issue contain examples of the meaningful results of looking and seeing: arsenical keratoses related to systemic malignancies, the many faces of cutaneous T-cell lymphoma, and nevi erupting with dysplastic changes following sunburn in immunocompromised AIDS patients. These are not cases from the dusty archives of an exotic locale, but occurrences in people living in our Garden State.

Meanwhile, there is special help for the special problems. Competent physicians specially trained in the techniques of Moh's surgery can root out difficult tumors, conserving healthy tissue, preventing recurrences, and making happier, healthier patients. Mole-studded members of melanoma-prone families can be followed carefully with New Jersey-bred technology which will reveal those suspicious lesions requiring excision. Patients with xeroderma pigmentosum, that rare caricature of all the ills visited upon the skin by ultraviolet, are studied not only for helping with their peculiar problem, but for the promise of better insights into the mysteries of cancer in general.

Whether every physician knows what epidermal Langerhans cells do, or how epidermal keratinocytes interact with lymphocytes, or what the cytokines are, may not be very important in helping most of our patients right now. The simple message of how to prevent skin cancers and ultraviolet damage already is available. Both the physician and the patient can perform regular cancer screenings of the integument. Teach the ways to recognize the early warning signs of cancer. Help the patient look and feel better, whether through use of topical tretinoin, sunscreens, or prompt surgical removal of early cancers. The patients will love you for it!

*"And that's what we mean,
When we say that a thing,
Is welcome as flowers that bloom in the spring!"**



Christopher M. Papa, MD
Guest Editor

*The Mikado, Gilbert and Sullivan.



WHEN IT COMES TO YOUR FINANCIAL HEALTH, YOU DESERVE A SPECIALIST.

There's never enough time in the day, or night, to manage a busy health care practice—and its finances. That's why Midlantic National Bank/North created the Medical/Dental Banking Group.

Whether you're starting a new practice, purchasing an established one, or buying into a group practice, see a Medical/Dental Specialist at Midlantic. We're professionals with an in-depth knowledge of your unique situation. We'll work with you on an individual basis in securing a loan for new equipment, leasehold improvements, or working capital. And, tailor a graduated repayment schedule based on your needs.

If you're just starting out, ask about Midlantic's "Healthy Start" Cash Flow Management Program—a conveniently scheduled series of one-on-one consultations regarding financial management for optimal return.

For more information, and to receive our brochure, "A Complete Financial Services Program for Health Care Professionals," speak with Patrick Robinson, our Vice President and Group Manager, at 1-800-633-0040, or (201) 881-5191.

Talk with a Midlantic Medical/Dental Specialist, today. We think you'll agree that in the long run, an ounce of prevention is worth a pound of cure.

Member FDIC
Equal Opportunity Lender

MIDLANTIC
Midlantic National Bank/North
The Hungry Bankers.

Sun Protection and Skin Cancer

RICHARD S. BERGER, MD

Sun exposure causes the majority of skin cancers. Ultraviolet radiation is important in the initiation and promotion of these cancers. Basal cell carcinomas, squamous cell carcinomas, and many melanomas can be prevented by the proper use of sun protection. Sun defense methods can reduce morbidity and death from skin cancer.

Skin cancer is the most common cancer, with over 500,000 new cases yearly in the United States. The rate of skin cancer has been increasing dramatically each year. The good news is skin cancer is the most easily prevented cancer. Epidemiologic studies point to the sun as the principal cause of 90 percent of squamous and basal cell carcinomas.¹ The sun has been implicated also in melanoma, which accounts for only 7 percent of skin cancers but 80 percent of deaths from skin cancer.² These three malignancies account for nearly all the cases of skin cancer, and all of these occur more commonly in fair-skinned individuals and are frequent in sun-exposed areas of the body. The prevalence of these tumors is considerably higher in the sunbelt states, in the white population, and in locations nearer the equator.

LIGHT WAVELENGTHS

The wavelengths of light that are considered the cause of skin cancer are a narrow band of the solar spectrum between 290 nm to 400 nm (Table 1). Wavelengths below 290 nm are very damaging to DNA but are filtered out by the ozone layer in our

atmosphere. Part of ultraviolet B light (UVB) (290-320 nm) also is filtered out by the ozone layer. The UVB which reaches our skin is absorbed in the epidermis while ultraviolet A light (UVA) 320 to 400 nm is absorbed in the dermis. Approximately ten times more UVA than UVB penetrates our atmosphere; still UVB is considered to be more important in producing skin cancers.³ Recent information indicates that UVA acts in concert with UVB in the genesis of these cancers.⁴

Supporting the indirect epidemiologic studies in humans are many direct experiments in animals. Ultraviolet (UV) radiation acts as an initiator and promotor of carcinogenesis.⁵ UVB damages DNA, and UV radiation suppresses the immune defenses of the host, allowing tumors to grow. There now is a consensus that sun exposure plays a major role in skin cancers and these rays produce changes in the skin associated with photoaging.^{6,7} This is a problem that afflicts everyone, although it is more noticeable and occurs at a younger age in those with fair skin. To many, photoaging is more threatening than the fear of cancer.

PROTECTION

Fortunately, there is evidence to show that sun protection not only helps to prevent problems, but actually allows repair of damaged skin and reversal of cancerous and photoaging changes. Animal studies have shown that applying sunscreens after the

Dr. Berger is clinical professor of medicine and chief, Division of Dermatology, UMDNJ-Robert Wood Johnson Medical School. Requests for reprints may be addressed to Dr. Berger, UMDNJ-Robert Wood Johnson Medical School, Division of Dermatology, Ferren Hall, One Penn Plaza, New Brunswick, NJ 08901.

appearance of tumors reduces the number of new tumors and prevents premalignant lesions from becoming invasive.⁸ Photoaging also can be prevented and improved by limiting ultraviolet damage. Photoprotection can take several forms such as wearing hats and other protective clothing, minimizing sun exposure during the hours of 10 A.M. to 2 P.M. when the sun (especially UVB) is the strongest, and applying sunscreens. Sunscreens act physically or chemically to provide a barrier to UV light (UVL) (Table 2). There are substances taken internally which offer sun damage protection and possibly cancer prevention, e.g. beta carotene, antioxidants, retinoids.⁵ In addition to increasing beta carotene in our diet, other changes may offer protection. Studies in mice have shown a low-caloric, low-fat diet results in fewer UV-induced tumors.⁹

SUNSCREENS

The use of sunscreens gives the best protection to exposed skin. When recommending a sunscreen agent, several factors must be considered: season of the year, time spent in the sun, and geographic location (altitude and latitude). Sunscreen variables include: sunscreen agent, potency or strength (Table 3), UVL spectrum absorbed, the solubility or water

resistance, and the base vehicle.¹⁰

The relative quantity of sunscreen protection is designated by a sun protection factor (SPF). SPF is the ratio of the time it takes to develop a minimal sunburn with a sunscreen compared to the time it would take to burn without a sunscreen. Clinical methods to determine sunscreen efficacy have been standardized.¹¹ Although the newer sunscreens have very high SPFs, it is important to point out that protection does not increase proportionally with the SPF number. For example, SPF 2 gives 50 percent protection, and SPF 15 produces 93 percent protection while SPF 34 gives 97 percent protection. Thus, there is only a 4 percent advantage between an SPF 15 and SPF 34. This only would be an advantage in the most sensitive individuals or in extreme conditions of sun exposure. It is possible that stronger preparations may cause more side effects. For most New Jerseyans, SPF 15 is sufficient protection.

The protection factor can be altered by the method of application of the product. In studies to determine the SPF, a measured amount of sunscreen is applied to a defined area. The actual amount of sunscreen applied by the patient may vary considerably. In fact, there often is great variation within the same area of the body, producing a mottled or patterned appearance after sun exposure. Many people have had the experience of developing a severe burn in an area where the sunscreen was inadvertently applied improperly.

Different sunscreen chemicals absorb specific wavelengths of the UVL spectrum. Patients at risk for skin cancer benefit from a broad-spectrum sunscreen. Also, a sunscreen must not burn or irritate the skin. Amyl dimethyl PABA is an excellent sunscreen but causes burning of the skin of the face during sweating in about 20 percent of the population. Since most people sweat when they are out in the sun, this chemical is seldom used. PABA, an often used sunscreen, is quite water soluble and stains certain white fabrics yellow, making it impractical for daily use. PABA also seems to be a more common cause of allergic contact dermatitis. However, any of the sunscreen agents can cause allergic dermatitis as can the components of the base.

Table 1. Solar spectrum—ultraviolet light.

UVC	UVB	UVA	Visible	Infrared
200nm	290nm	320nm	400nm	760nm

UVC—Absorbed in upper atmosphere by ozone. Does not reach earth.

UVB—Burning spectrum, highest from 10 A.M. to 2 P.M. Damages DNA.

UVA—Tanning spectrum, early morning, late afternoon.

Table 2. Sunscreens.

I. Shades—Physical Barriers

A. Powders

1. Zinc oxide Titanium dioxide

B. Grease R.V. Paque

II. Chemical Screens

A. Partial Spectrum

1. PABA
2. PABA esters (octyl dimethyl PABA, amyl dimethyl PABA)
3. Digallyl trioleate
4. Cinnamic acid
5. Methyl anthranilate

B. Complete Spectrum

1. Benzophenones, i.e. oxybenzone
sulisobenzene
2. Combinations

C. Other—Quinine, salicylate esters, beta-carotene

III. Stains

A. Dihydroxyacetone

Table 3. Potency or strength of sunscreen.

Erythematous transmission in decreasing order at 3 percent concentration*

Homosalate (greatest transmission)
Sulisobenzene
Oxybenzone
PABA
Glyceryl PABA
Octyl dimethyl PABA
Amyl dimethyl PABA (lowest transmission)

*Decreasing transmission = increasing protection

Perfumes are a common source of allergic reactions. One popular product contained a fragrance that proved to be a source of photoallergic problems. With more frequent use of sunscreens, we can expect an increase in the incidence of contact dermatitis.

The vehicle selected is important for patient compliance. A greasy base is inappropriate for most acne patients, and an alcohol base usually is too drying for older individuals. The carrier vehicle also may add to the substantivity of the product, and, therefore, its water resistance. Some products, i.e. Presun 15™ lotion and the original Sundown™, have a polymer in the base which adheres to the skin holding with it the sunscreen. Since product complaints are frequent, patients should be counselled to persist in finding a sunscreen that does the job and feels good.

Sunscreens should be applied to dry, washed skin. To give the sunscreen time to attach to the skin before sweating begins, application in the early part of the day is advised. Re-application of sunscreens is recommended after swimming and profuse sweating. Perspiration can wash sunscreens into the eyes, causing irritation; using less on the forehead and wearing a protective hat is a practical solution.

It is prudent to point out that effective sunscreens are not intended to be used so that one can spend unlimited time in the sun. Increased exposure negates many of the benefits of using sunscreens. Sunscreens allow people to engage in necessary or normal outdoor activities. Sunbathing and the use of tanning salons need to be discouraged.

MINIMIZING SUN DAMAGE

Other useful information includes:

1. The most dangerous exposure time is between 10 A.M. and 2 P.M., especially in the summer months. The sun intensity is greatest at these times and there is a greater proportion of UVB irradiation.
2. Sun damage occurs at nearly the same rate on hazy days. Clouds filter out infrared, but do not filter out much UVL unless they contain a high

content of hydrocarbons.

3. Sun intensity increases as one approaches the equator and in high altitudes.

4. Reflective surfaces, such as sand, water, and snow, make hats and umbrellas almost useless necessitating sunscreens.

5. UV rays pass through water and loosely woven or wet clothing.

6. Lasting sun damage occurs from severe burns.

7. Cumulative sun damage is acquired from normal outdoor activities (incidental every day exposures); therefore, susceptible individuals need daily use of sunscreens.

For most people in New Jersey, the daily use of sunscreens is recommended for the months of May through September. At-risk patients should be advised to apply sunscreen daily, whether or not the sun actually is shining.

In older individuals using complete sun protection, the physician should prescribe vitamin D supplements. The skin in the elderly does not synthesize the active forms of vitamin D as readily as youthful skin, and older individuals are less likely to eat vitamin D-enriched foods, such as milk.¹²

SUMMARY

Cumulative damage from UVA and UVB, the main cause of skin cancer, is preventable. Maximal sun protection should be used on a daily basis, starting at an early age. A broad spectrum SPF 15 sunscreen is best particularly for fair-skinned individuals and those with a family history of skin cancer. It is important to remember that there is no such thing as a healthy tan—a tan is a sign that damage has occurred. However, a gradual tan is sun protective and is better than repeated sunburns. The use of tanning booths should be discouraged. Although it often is difficult to get people to practice cancer prevention, it is possible to get compliance by noting that these measures will prevent the disagreeable cosmetic changes equated with aging. ■

REFERENCES

1. *Causes and Effects of Stratospheric Ozone Reduction: An Update*. Washington, D.C., National Academic Press, 1982.
2. Armstrong BK: Epidemiology of malignant melanoma: Intermittent or total accumulated exposure to the sun. *J Dermatol Surg Oncol* 14:835-849, 1988.
3. Forbes PD, Davies RE, Urbach F, Cole C: Photocarcinogenesis, in *Photobiology of the Skin and Eye*. Dekker, New York, NY, 1986.
4. Lowe NJ: UVA Cutaneous Effects and Photoprotection. Scientific Exhibit AAD meeting, 1987.
5. Deleo VA: Prevention of skin cancer. *J Dermatol Surg Oncol* 14:902-906, 1988.
6. *Photoaging/Photodamage as Public Health Concern*. American Academy of Dermatology, 1988.
7. Engel A, Johnson M, Haynes SG: Health effects of sunlight exposure in the United States. *Arch Dermatol* 124:72-79, 1988.
8. Kligman L: Considerable repair is seen possible in photodamaged skin. *Derm News*:2, 1987.
9. Rusch HP, Kline GE, Baumann CA: The influence of caloric restriction and of dietary fat on tumor formation with ultraviolet light. *Cancer Res* 5:431-435, 1945.
10. Berger RS, Mezick JA, Papa CM: Design and evaluation of a water-resistant sunscreen preparation. *J Soc Cosmet Chem* 29:641-649, 1978.
11. Morton JJP, Murphy EG: Sun protection factors: Regulatory issues and methods of determination. *Photobiology of the Skin and Eye*. Dekker, New York, NY, 1986.
12. Fine RM: The fine page: Sunscreens and cutaneous vitamin D synthesis. *Intern J Derm* 27:300-301, 1988.

NJ Skin Cancer Screening Program

CHRISTOPHER M. PAPA, MD

Free skin cancer detection and prevention programs have been conducted throughout the United States. The New Jersey experience is outlined. Over 9,500 patients have been screened by a volunteer force of professionals. Patient education, an integral part of the program, stresses self-examination, recognition, and prevention of common cutaneous malignancies.

For the past four years, a free skin cancer detection and prevention program has been available to the people of New Jersey. It is a grassroots effort by members of the Dermatological Society of New Jersey, in response to a mandate of the American Academy of Dermatology. Thousands of our fellow citizens have participated in the program, being examined for, and educated about, the common cutaneous malignancies.

Dr. Papa is guest editor of this issue, and clinical professor of medicine (dermatology), UMDNJ-New Jersey Medical School. Requests for reprints may be addressed to Dr. Papa, UMDNJ-New Jersey Medical School, Division of Dermatology, Ferren Mall, One Penn Plaza, New Brunswick, NJ 08901.

BACKGROUND

In 1984, the American Academy of Dermatology established a national program aimed at increasing public awareness of the value of early detection, and prevention of skin cancers. Part of the impetus for the program was derived from the great interest generated by the well-publicized treatment of former President Reagan's basal cell carcinoma of the nose. With the support of a joint Congressional resolution, the nation's chief executive declared April 1985 National Skin Cancer Awareness Month, and a national melanoma/skin cancer prevention campaign was inaugurated by the American Academy of Dermatology to coincide with the period. All dermatologists were encouraged to participate in this vol-

Table 1. *Patients utilizing the New Jersey Melanoma/Skin Cancer Detection Program.**

	Patients Screened	Actinic Keratoses	Basal Cell Cancer	Squamous Cell Cancer	Dysplastic Nevus	Malignant Melanoma	Total Referred
1985	419	75	50	6	17	9	157
1986	1,927	203	154	4	96	23	480
1987	3,786	293	201	8	199	30	731
1988	<u>3,421</u>	<u>549</u>	<u>222</u>	<u>29</u>	<u>216</u>	<u>41</u>	<u>1,057</u>
TOTAL	9,553	1,120	627	47	528	103	2,425

*All numbers refer to patients.

unteer program, and received guidelines on establishing local screenings. Promotional and educational material was provided, as well as patient reporting forms, the latter intending to yield data on the results of the programs.

The Dermatological Society of New Jersey membership endorsed a statewide program which would be sponsored and coordinated by the group. A Melanoma/Skin Cancer Detection and Prevention Task Force was established, with representatives from the Dermatological Society, the New Jersey Chapter of the American Cancer Society, the New Jersey State Department of Health, UMDNJ-Robert Wood Johnson Medical School, UMDNJ-New Jersey Medical School, and the Middlesex County Public Health Department.

The goals of the state program are to establish a system of free screenings for the detection of early, treatable skin cancers, to disseminate information, to educate the public on the prevention of skin cancers, and to collect data on the types and prevalence of these malignancies within New Jersey.

THE NEW JERSEY EXPERIENCE

Governor Thomas H. Kean gave this program his personal endorsement. A proclamation was issued designating April 20 and 21, 1985, as "Free Skin Cancer Detection and Prevention Weekend." Although only a modest number of people were screened during the first year (Table 1), the experience provided the Task Force with the necessary background to improve the quality and scope of programs in succeeding years.

The screenings are conducted by volunteer dermatologists at a variety of settings, primarily hospitals (Table 3) and industrial sites (Table 4), but also in county and municipal health facilities, and at health fairs. Each site is responsible for disseminating its own promotional publicity, although

news, radio, and television material is made available by the American Academy of Dermatology.

At the screening, each patient completes a portion of the registration and report form (Figure), providing personal data, and signs an informed consent and release statement (Figure). The examining physician indicates the type and site of detected lesions, estimates the degree of sun damage, specifies the extent of the examination, and states whether the patient needs referral for further therapy (Figure). The doctor or trained health professional explains the findings to the patient, emphasizing the patient now is responsible for obtaining confirmation of the diagnosis and further therapy. No attempts are made to steer the patient to the examiner or the sponsoring institution. The dermatologists specifically are directed not to pass out business cards. If the patient has no personal physician, or requests referral to a specialist, an extensive listing of board certified members is provided so the patient may choose a physician who is available.

The registration and report form is a three-copy NCR document. The top white sheet is retained by the sponsoring facility, while the patient receives the bottom yellow and pink copies. These are to be presented to the treating physician, to share the findings of the examination, and to obtain a followup report. An envelope addressed to the Dermatological Society of New Jersey also is provided so that the treating physician can mail the information requested at the bottom of the form. This will ascertain when and where the patient was seen, whether the diagnosis was confirmed, request for a pathology report, and, the definitive therapy (Figure).

An important and integral part of the screening examination is the education of patients. In industrial settings, there often is a formal presentation which precedes the actual screening; the public is taught how to recognize skin cancers, and educated

Table 2. 1985-1988 results from the National Melanoma/Skin Cancer Detection and Prevention Program.

	Patients Screened	Precancerous Lesions*	Malignant Melanoma	Basal Cell	Squamous Cell	Total Lesions Found
1985	32,000	2,479	97	1,056	163	3,795
1986	41,486	10,366	262	3,049	398	14,075
1987	41,649	9,136	257	2,798	302	12,493
1988	67,124	14,494	435	4,457	474	19,860
TOTAL	182,259	36,475	1,051	11,360	1,337	50,223

*Actinic keratosis and dysplastic nevus.

Table 3. Hospitals participating in screening programs.

Bayshore Community Hospital
 Community Memorial Hospital
 Elizabeth General Medical Center
 Freehold Area Hospital
 Hackensack Medical Center
 Hackettstown Community Hospital
 Hamilton Hospital
 Hunterdon Medical Center
 John F. Kennedy Medical Center
 Monmouth Medical Center
 Riverview Medical Center
 Robert Wood Johnson University Hospital
 Shore Memorial Hospital
 Somerset Medical Center
 Saint Barnabas Medical Center
 Valley Hospital
 Zurbrugg Memorial Hospital

Table 4. Industries participating in screening programs.

A.T. & T. Bell Laboratories
 A.T. & T. Corporation
 Asbury Park Press
 Bell Communications Research
 Campbell Soup Company
 Hewlett Packard
 Krum & Forster Insurance
 McGraw Hill
 Mutual Benefit Life Insurance
 Ortho Diagnostics
 Prudential Asset Management
 Prudential Insurance Company
 Radio Corporation of America

about their significance and prevention. Self-examination of the skin is encouraged, as is the use of sunscreens. Educational pamphlets and brochures available from the American Academy of Dermatology, the American Cancer Society, the National Cancer Institutes, and the United States Department of Health and Human Services are distributed. A variety of sunscreen samples usually find eager hands ready to carry them off for trial. The use of VCR tape presentations, available from the above sources, is effective in registration areas while patients are waiting to be seen, or for further details following the examination.

The results of the four years' screening programs are shown in Table 1. When multiple diagnoses were present in one patient, only the more severe or important lesion was tallied. Bowen's disease, the intraepidermal carcinoma, was assigned to the squamous cell carcinoma group, and lentigo maligna, the intraepidermal melanoma, was counted as a melanoma. While other malignancies are detected, e.g. Kaposi's sarcoma, and additional referrals made for interesting benign lesions which required care, these are not included in the statistics.

A comparison of the New Jersey experience with the results of the national program (Table 2) over the same period, shows rough equivalence. About 25 percent of those examined were referred, with the greatest number of lesions being the premalignant actinic keratoses and dysplastic nevi. Approximately 6 percent of the referrals were for basal cell carcinomas and 0.6 percent for squamous cell carcinomas. While the national program uncovered 0.5 percent malignant melanomas, the New Jersey data had twice that amount at 1.0 percent. The number of patients screened in New Jersey was 5.2 percent of the national total.

Demographic data has not been analyzed, but the experience seems to confirm the conventional wisdom that the public screenings yielded a larger number of referrals than those at industrial sites,

MELANOMA/SKIN CANCER SCREENING PROGRAM REGISTRATION AND REPORT FORM

Screening Location _____ Date

--	--	--	--	--	--

(Please print)

Name _____ Age

--	--

 Sex

--

Address _____ City _____ Zip

--	--	--	--

Telephone # _____ Occupation _____ How long?

--	--

Spouse's Name _____ Is your work done mainly? Indoors _____ (1) Outdoors _____ (2)

History of skin cancer? Yes _____ No _____

Have you any spots which have changed in size, color, shape, or thickness, or bled recently? Yes _____ No _____

Have you ever been examined at a skin cancer screening program before? Yes _____ No _____

In connection with Melanoma/Skin Cancer Screening Day, I hereby release the presiding physician, and the sponsoring agencies of all responsibility in connection with this examination. Any findings may be used to compile data for a program study with the understanding that my name will not appear in any publication of these data. I understand that the findings will be reported to me with recommendations, and I am responsible for any expense involved in following those recommendations. I also understand that this is a rapid screening and does not constitute a complete cancer examination. The screening is voluntary and free of charge. It is understood that:

1. The data derived from this examination are to be considered preliminary only and do not constitute or substitute for a complete diagnostic examination by my own physician.
2. The responsibility for initiating any followup examinations for abnormalities identified at the Melanoma/Skin Cancer Screening Program lies with me as the person responsible for my own health and not with any participating organization.
3. Health volunteers will have access to my test results for the sole purpose of ascertaining if the results are abnormal and aiding me in initiating a followup examination; and
4. No other individual or agency will have access to my individual test results without express written permission from myself.

I HAVE READ, UNDERSTOOD, AND ACCEPT THE ABOVE PARAGRAPHS:

Witness _____ Date _____ Participant's Signature _____ Date _____

Dermatologist or Family Physician _____

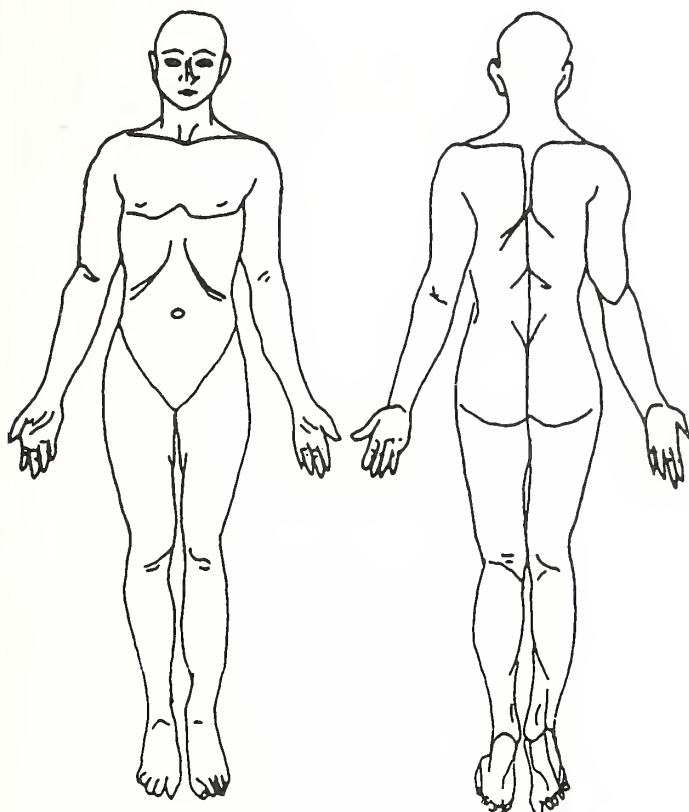
Address/Telephone # _____

Figure. Form used by the Dermatological Society of New Jersey for screenings.

MELANOMA/SKIN CANCER SCREENING PROGRAM REGISTRATION AND REPORT FORM

Screening Physician Please Complete The Following:

Indicate Location
of Lesions



PRESUMPTIVE DIAGNOSIS

Check all that apply

1. Actinic keratosis _____
2. Basal cell carcinoma _____
3. Dysplastic nevus _____
4. Melanoma _____
5. Squamous cell carcinoma _____
6. Other _____

DEGREE OF SUN DAMAGE

- Mild _____ (1)
- Moderate _____ (2)
- Severe _____ (3)

EXAMINATION

- Complete _____ (1)
- Sun-exposed _____ (2)
- Other _____ (3)

- Referred _____ (1)
- Not Referred _____ (2)

Examiner _____

TREATING PHYSICIAN PLEASE COMPLETE THE FOLLOWING

Your name and address

Date patient seen _____ / _____ / _____

Your diagnosis _____

Pathology (attach copy) _____

Treatment _____

Figure. Form used by the Dermatological Society of New Jersey for screenings.

Table 5. The 1986 followup results.

	Patients	Percentage
Physician treated— report received	54	42.5
Physician treated— no report	41	32.3
Patient noncompliant	32	25.2
Pathology report	22	17.3
Total patients referred	127	100

because the patients were older, predominantly white, with obvious sun-damaged skin and a surfeit of epithelial cancers and precancers.

INDUSTRY OUTREACH PROGRAM

The substantial increase in numbers of patients screened during the 1987 and 1988 campaigns (Table 1) is the result of programs conducted at a variety of industrial sites throughout the state. The employees examined in these screenings were younger, healthier people than those who sought out the local screens at hospitals, clinics, and fairs. They represent a special opportunity for prevention of cancers. Many do not see physicians for any illness and are not likely to have had a recent physical examination. Younger and middle-aged adults which make up the active workforce represent the group most at risk for malignant melanoma. Additionally, the educational program has the best chance for success, starting these people on a lifetime cancer awareness and detection program. Both the younger adults and their children stand to benefit the most from active prevention measures, including the use of appropriate sunscreens.

The Dermatological Society of New Jersey offered these services through the occupational health professionals in the state, using presentations, letters, and notices in newsletters. The corporations which participated are listed in Table 4.

PROBLEMS

The figures reported for the four years of screening programs seem impressive; in fact, they are an understatement of the results. The Task Force was aware of other screening programs conducted throughout the time period (some groups had requested and received the registration and report forms and educational materials) which never provided a summary of their results. Some groups sent the forms back to the American Academy of Dermatology, despite instructions to the contrary

printed on the forms and reinforced with the written guidelines provided.

A more vexing deficiency is the inability to obtain meaningful followup information on the disposition of the referrals, and the confirmation of diagnoses and therapy. The screenings conducted at the Robert Wood Johnson University Hospital devote a great deal of time and energy in an attempt to retrieve this vital data. The exit interviews are managed by volunteer nurses from the Middlesex County Department of Health, who impress upon each referred patient the importance of the followup information. All referrals which do not have a return followup document receive at least three telephone calls and, failing contact, a letter requesting the information. The 1986 screening returned the greatest yield of followup data, but it was very disappointing (Table 5). About three-quarters of the referred patients actually saw physicians, and only in slightly more than half of these (one third of those referred) did the treating physician provide followup information. Pathology reports were available on only 17 percent of the tumors. It is curious that so many patients who came voluntarily for the screening would then ignore the recommendations of the professional. Some expressed indignation at the followup attempts made by the nurses. Even more puzzling was the lack of courtesy shown by physicians who were too busy to fill out the return information request; in 1986, physicians were provided with stamped, addressed envelopes. For the referrals generated, it would be the very least expected. It also was astonishing to have an irate family physician write a scathing return note asking us to "leave his patient alone." The screening dermatologists did not hunt for, or otherwise dragoon, any patients into attending the screenings.

CONCLUSION

The skin cancer screening program has been a reasonable success given its youth, and the problems inherent in any wholly volunteer effort which engages busy professionals, each juggling the exigencies of a day-to-day practice. Those physicians who freely gave of their time and skills have done good for the patients and the profession. They warrant a heartfelt "thank you" for their fine, altruistic contributions. The Melanoma/Skin Cancer Detection and Prevention Task Force intends to continue encouraging these annual programs, and envisions even greater growth in the coming years. It fervently is hoped that those physicians who participated will continue to provide their expertise and assistance, and that others may avail themselves of the opportunity, and personal pleasure, of medical volunteerism and public service. ■

Tretinoin Therapy for Precancerous Skin

CHRISTOPHER M. PAPA, MD

Although few actinic keratoses eventuate as squamous cell carcinomas, these precancerous lesions cannot be ignored. A medical regimen of topical tretinoin use and sun protection appears to be effective in treating and preventing these precancers, with the added cosmetic benefits of ameliorating the alterations which accompany sun damage on exposed skin.

International press coverage of the 1987 and 1988 annual meetings of the American Academy of Dermatology helped fire intense public interest over the use of topical tretinoin (RETIN-A™) for sun-damaged skin. Although this was sparked by a report of a controlled study,¹ observations of the cosmetic benefits were made in 1970, using the drug for actinic keratoses,² and again in 1971 in a pioneer clinical acne study using women inmates.³ Actually, the use of tretinoin (vitamin A acid, all-transretinoic acid) for actinic keratoses dates back to 1962, with the very first publication dealing with its clinical prospects in dermatology.⁴

In 1962, at the Hospital of the University of Pennsylvania, Philip Frost, MD, a fellow dermatology resident, treated a family with congenital ichthyosiform erythroderma using an extemporaneously compounded tretinoin ointment. It probably was the very first topical tretinoin therapy in the United States. Our professor and mentor, Albert M. Kligman, MD, who would later champion its use in acne, encouraged me to join Johnson & Johnson

Research in 1969. I participated in the creation of its Dermatological Division and the development of RETIN-A™ products. I have used topical tretinoin on hundreds of patients with sun-damaged, precancerous skin, as well as for acne vulgaris. The observations which follow are based on experience, not a well-controlled, double-blind study, and though biased, are intended to assist others in the appropriate use of a valuable and potent drug. The results of a recently completed multicenter clinical study of 300 patients with actinic keratoses are in general agreement with the observations reported in this paper.⁵

ACTINIC KERATOSES

The red, scaly, superficial, rough, occasionally pigmented lesions which vary from a few mm to cm in size, occur on the sun-exposed portions of the body, primarily the face, ears, dorsa of the hands, and extensor forearms. The term solar keratosis is synonymous, emphasizing the major role of ultraviolet radiation in its origin; because occurrence increases with age, they also have been called senile keratoses. Actinic keratoses may occur in young people, if they are fair and have had sufficient occupational or recreational sun exposure. The even more common benign tumor of seborrheic keratosis, on the other hand, increases with age and confusing-

Dr. Papa is a clinical professor of dermatology, UMDNJ-Robert Wood Johnson Medical School, New Brunswick, and guest editor of this issue. Requests for reprints may be addressed to Dr. Papa, UMDNJ-Robert Wood Johnson Medical School, Ferren Mall, One Penn Plaza, New Brunswick, NJ 08901.

ly has been called a senile keratosis. The term should be permanently discarded from medicine.

Some untreated actinic keratoses undoubtedly progress to squamous cell carcinoma of the skin, a fact taken as sufficient reason for physicians to regard them as precancerous. Existing lesions are removed, and patients are counselled in sun protection procedures designed to minimize the problem. A variety of destructive techniques will eradicate the abnormalities, which are localized within the epidermal layer of skin. Electrodesiccation and curettage, treatment with caustics, e.g. trichloroacetic acid, and cryosurgery using liquid nitrogen, all have their advocates. The keratoses are removed, but frequently result in hypopigmented, atrophic spots or scars. These destructive methods all come with a financial price, as well.

A recent study of over 40,000 at-risk Australians questions the wisdom of the wholesale destruction of actinic keratoses. The results indicated that as new lesions appeared, others spontaneously remitted, and the annual incidence of squamous cell carcinoma was considerably less than 1 percent for each keratosis present at the beginning of the year.⁶

Medical Treatment of Actinic Keratoses. Since the various ablative techniques are costly, and may leave unwanted cosmetic sequelae, it is reasonable to consider the alternate therapy, use of topically applied drugs. The more widely known and utilized 5-fluorouracil (FU) treatment has severe limitations. Topical tretinoin seems to have the best prospects for the near future.

Topical 5-Fluorouracil Therapy. The fortuitous observation that systemic FU cleared actinic keratoses ultimately led to its topical use.^{7,8} FU is available as a cream or solution to be applied to the obvious keratoses, or to suspicious areas of sun damaged skin. The medication reacts with the visible lesions, and unmasks microscopically damaged sites as well, while the intervening normal skin remains unaffected. The precancerous skin undergoes rapid, often dramatic, changes in response to the medication. After several days, susceptible areas become inflamed and, over the next few weeks, proceed from redness and edema through oozing, vesiculation, erosion, and ulceration. The reaction quite resembles a severe case of poison ivy dermatitis, and the patient is as discomforted by itching, burning, and pain. When large areas unexpectedly explode, they truly look awful. Topical steroids either used concomitantly, or at the end of therapy ameliorate symptoms, and healing proceeds over the next few weeks. Residual redness and pigmentary changes may persist for longer periods. Unfortunately, after stopping this acute treatment, the patient may expect, usually within the year, the development of

new or recurrent keratoses which require additional therapy. Even the most compliant and motivated patients, however, are loathe to repeat the experience.

Topical Tretinoin Therapy. The currently available 0.05% tretinoin cream (TC) offers a much more acceptable program for the topical treatment of actinic keratoses. It will be tolerated easily by patients, and even embraced for the obvious cosmetic benefits associated with its continued use. Uninterrupted therapy seems to prevent or at least palpably retard the development of new lesions. Anecdotal experiences with two patients at the severe end of the sun damage problem are illustrative.

CASE REPORTS

A 63-year-old, fair-skinned, blue-eyed gentleman of Celtic origin is a "walking skin cancer." His face, back, and chest were first assaulted by x-ray therapy for severe, teenage acne. Later, in Egypt, working shirtless, as a field engineer, the entire upper half of his body received the full brunt of constant, strong actinic radiation.

Eleven years ago, he had numerous disfiguring surgeries to his face, ears, lips, arms, and upper torso. The full spectrum of epithelial tumors had been removed; basal cell carcinomas, squamous cell carcinomas, and keratoacanthomas. It was usual for me to remove at least three or four new cancers every month! After beginning TC (practical only for the face), no new lesions developed in the treatment area. The plastic surgeon, who was following the reconstruction work on the patient's ear and lip, unaware of the therapy, called to find out why the skin looked so good. There remained the problem of what to do for the larger body surfaces which still were developing cancers. An early report indicated that systemic retinoid therapy would work, and prompted a trial of isotretinoin (Accutane®).⁹ At doses of approximately 1 mg/Kg, the remaining actinic keratoses lit up and disappeared; no cancers were removed for the next two years. Unfortunately, at about the 18th month of treatment, gradually worsening muscle aches, weakness, and joint pains precluded further therapy. Lower dosage regimens were tried and were ineffective. Although the patient continues to use TC on his face, three or four cancers are removed from his torso at each monthly visit. Continued retinoid treatment obviously is required for prophylaxis.

An 82-year-old farmer's wife, who did her share of work alongside her mate, has severely sun-damaged skin. Monthly tumor removal from the face was normal, and there was no persuading her to try a second course of FU for the obvious actinic keratoses. Once on TC, the surgery stopped, and the patient and her

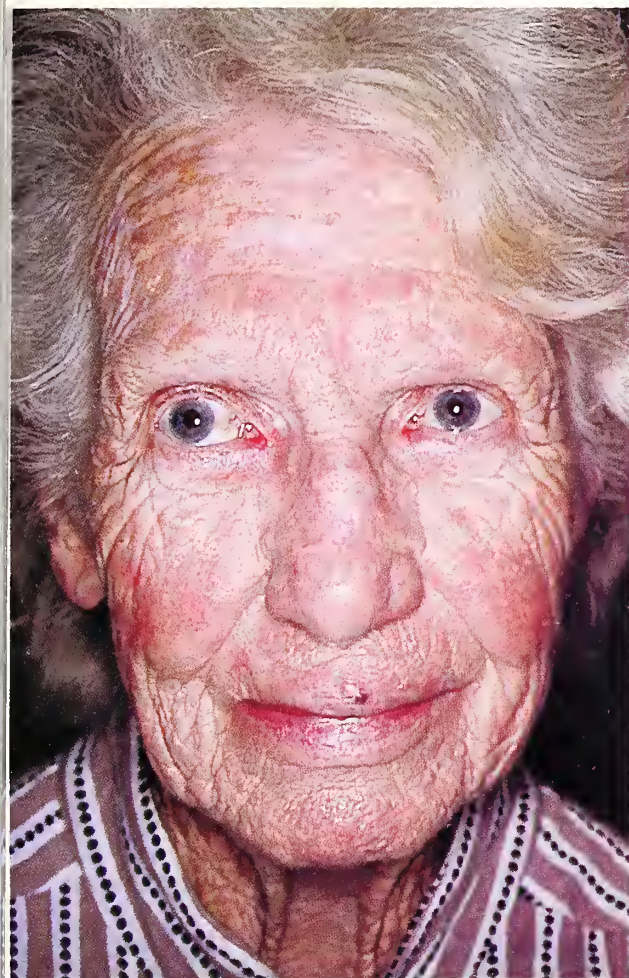


Figure 1. After several years of topical tretinoin therapy, no new actinic keratoses or skin cancers developed, and the patient is pleased with her improved skin and rosy glow.



Figure 2. This photograph, taken eight months after Figure 1, demonstrates the actinic keratoses that returned when retinyl palmitate was used instead of tretinoin cream.

friends and family delighted in the overall improvement in her skin. The deep furrows acquired over her lifetime will not disappear, but the mottled pigmentation has lightened, the cheeks are once again smooth, and her face "glories all effulgent" (Figure 1). As part of a little experiment, she consented trying one of the recently marketed retinyl palmitate (vitamin A) creams in place of the TC. These over-the-counter substitutes proliferated with the media storm generated by the reports on TC. Within two months, her actinic keratoses had reappeared (Figure 2), convincing evidence of the lack of value of the would-be imitator products, as well as the need for ongoing TC therapy.

WHO GETS THE DRUG?

The approved indication for TC is the treatment of acne vulgaris. The drug has been available for prescription since the early 1970s and has been used safely as continual therapy by children, teenagers, and adults for almost 20 years. The acne patients

are the first ones I treat for cancer prevention, telling them to continue medication, and instructing them about sun avoidance, and the use of sunscreens. The middle-aged adults who seek the "wrinkle removing drug" are likewise good candidates to begin the same regimen. If wrinkles are present, it is due to sufficient sun damage. Although there may be no clinically apparent actinic keratoses, lurking invisible microscopic precursors will respond to TC. The patients with the clearest need to start such therapy are those who have had a skin cancer, or actinic keratoses, or who manifest some or all of the unpleasant stigmata of sun damage. They generally are fair-skinned, freckled, light eye-colored people, with dilated telangiectatic vessels on their cheeks and nose, inflammatory papules and pustules of rosacea, yellowish thick-skinned plaques of elastotic degeneration, gaping hair follicles, frank blackheads, mottled pigmentation, brown macules of actinic lentigo, and small, yellow, perifollicular donuts of sebaceous hyperplasia.



Figure 3. Barely visible actinic keratoses in the middle of the cheek prior to starting topical tretinoin cream. The patient wanted "the wrinkle cream" and had only the mildest evidence of sun damage.

METHOD OF USE

There is an art to prescribing topical tretinoin therapy. It begins with the knowledge that the gel and solution forms available, although of lower concentration than the TC, nonetheless, are more potent products by virtue of their alcoholic vehicles. These are admirably suited to address the needs of the typical greasy-skinned adolescent acne patient, but have no place in the treatment of adult, sun-damaged skin. Every patient, regardless of conditions or treatment preparation must be taught how to use the medicine and what to expect during the treatment.

Gentle face washing is advised, using a mild, preferably unscented, soap. A glycerine bar soap "for dry skin" and a liquid "extra mile acne skin cleanser" by Neutrogena Corporation are suitable. For patients who rail at the expense, I recommend a generic nonscented baby shampoo of the "tearless" variety. Once daily, bedtime application is specified,



Figure 4. The same patient 28 days later, after nightly application of 0.05 percent tretinoin cream to the entire face. Only the actinic keratosis is reactive. With continued therapy, the lesion was entirely gone within the next month.

since the tretinoin is susceptible to ultraviolet degradation. The patient is advised to wait 20 minutes after washing and drying before using TC because there is more rapid absorption through wet skin and a tendency to produce unnecessary inflammation. (A pea-sized sample of cream applied to the back of the hand will easily spread to cover the skin from the knuckles to a few inches above the wrist.) The only trouble encountered by the use of TC is the irritation that comes from the application of excessive amounts. In actual use, a pea-sized quantity is dabbed on three spots on the face: in the center of the forehead and center of each cheek. The cream is spread gently in either direction across the forehead, but only in one direction, away from the corners of the eyes, mouth, and nose, on the cheeks. The little cream which adheres to the applying fingers then is used over the nose itself, and finally around the mouth and chin. The cream tends to migrate toward the center and lower portion of the face, anyway, so that it still receives its fair share of medication. A useful caution is, "If you get a red, peeling muzzle, it's a sure sign you are using too much medicine."

Each patient also needs to be told how to protect himself from further sun damage. Use of daily sunscreen SPF15 each morning, from May through September, is advocated for the New Jersey population. Multiple samples of different sunscreens are provided since there is a great deal of individual sensitivity to the variety of marketed products. Advice is given to select the sunscreen most comfortable and compatible, and continue with its use. Cosmetics may be used, although tretinoin-treated skin is sensitive to heavily perfumed, alcoholic products such as colognes and aftershave lotions. Nonscented moisturizers judiciously applied during the early weeks of therapy and the cold, dry, winter

months masks a slight flaking produced by the drug. Patients wintering in southern latitudes need sunscreens with higher SPF numbers, and the waterproof, film formers are recommended for skiing enthusiasts, since they help protect against "wind-burn" as well.

COURSE OF EVENTS

The physician must be familiar with the many skin events which occur once TC therapy is started, and the information must be imparted to the patient. An uninformed individual is likely to misinterpret a benefit as a "side effect" or "adverse reaction," and discontinue therapy at a critical point, where increased treatment actually is indicated.

During the first two weeks, the facial skin will exhibit a very fine, noninflammatory asymptomatic, scaling. It is a time of temporary speed up of epidermal growth and renewal, with increased shedding of the dead, outer horny layer of skin. Over the next few weeks, isolated inflammatory papules or pustules may appear as the drug works on pre-existing, inapparent acne lesions. These resolve in a matter of days, and continued use of the acne treatment medication, helps prevent the formation of new blemishes.

Within one or two months, precancerous islands of skin will become visible as small, pink or reddish, slightly scaly lesions (Figures 3 and 4). Patients with prior skin cancers recall the tumors looked like that at their onset. Once these reactive lesions are disclosed, the patient increases the application of TC, morning and night, to the spots, while maintaining the overall once nightly total face application. This twice daily application is continued for six weeks, during which time most of the lesions will simply disappear. Occasionally, the drug will temporarily efface the full thickness of the epidermis at one small spot and present as a tiny crust or fleck of blood. Forewarned patients accept this calmly, and the skin is repaired in a matter of a few days. Usually the microscopic damage is limited to the upper portions of the skin, which loses its protective functions, allowing other materials to quickly permeate. Soaps

and perfumed products, in particular, cause minor discomforts for a short while. Continued application of TC restores the skin to its former normal appearance and functioning.

If the putative keratoses/cancer do not vanish within the allotted six weeks, the 0.1 percent cream is prescribed for twice daily application to the sites for the next month. The nightly total face application of 0.05 percent TC is continued. Lesions which persist are treated with FU for three weeks. The very few which escape this medical therapy are treated surgically. These invariably turn out to be either hyperplastic actinic keratoses or early basal or squamous cell cancers. Although the medical therapy seems to be a lot of work to get to the same point as the destructive techniques, very few lesions actually require this type of intervention. Meanwhile, the patient is spared the rigors of FU, and the postdestructive scars.

If the extensor forearms and backs of the hands are to be treated, twice daily application is required, and frequently the 0.1 percent TC must be employed. A similar regimen is recommended for the treatment of bald pates and the rims of the ears, which are affected with the precancerous lesions.

CONCLUSIONS

A combination regimen which incorporates tretinoin to prevent further damage, the topical therapy described, and, as a last resort, surgical destruction, will expeditiously dispatch these precancers. The "fringe benefits" are considerable, with amelioration of sun-damaged skin, the prevention of new tumors, and the relief from the clinical and financial costs of the destructive methods. Since those patients who actively seek TC as a "wrinkle cream" are the people who will benefit the most from early intervention, separation into a "cosmetic-only treatment" idea is spurious. Third-party payers who take this short view of the capabilities of TC will deny patients the care which will yield healthier skin and fewer future surgical bills. Until a safer systemic retinoid is developed, TC should be the cornerstone of a most agreeable way of eradicating and preventing actinic keratoses. ■

REFERENCES

1. Weiss JS, et al.: Topical tretinoin improves photo-aged skin. *JAMA* 259:257-532, 1988.
2. Barranco VP, et al.: Response of actinic keratoses to topical vitamin A acid. *CUTIS* 6:681-685, 1970.
3. McGillis TJ, et al.: Topical vitamin A acid in the management of comedo acne. *CUTIS* 7:144-150, 1971.
4. Stüttgen G: Zur Lokalbehandlung von Keratosen mit vitamin A—Saure. *Dermatologica* 124:65-80, 1962.
5. Thorne EG: Personal communication, Ortho Pharmaceutical Corp.
6. Mark R, et al.: Spontaneous remission of solar keratoses: The case for conservative management. *Br J Dermatol* 115:649-655, 1986.
7. Talkson G, Schulz EG: Skin changes in patients treated with 5-fluorouracil. *Br J Dermatol* 74:229-236, 1962.
8. Goette DK: Topical chemotherapy with 5-fluorouracil. *J Am Acad Dermatol* 4:633-649, 1981.
9. Peck GL, et al.: Chemoprevention of basal cell carcinoma with isotretinoin. *J Am Acad Dermatol* 6:815-823, 1982.

We're putting lives back together.

As a physician you've probably seen it. A family's struggle against alcohol or drugs. A man or woman afraid to ask for help in dealing with depression. A young girl hiding an eating disorder behind a smiling face or popular personality.

At the Carrier Foundation, we work with physicians in treating troubled adolescents and adults. Unlike most general hospitals, all our resources are dedicated to this mission. And have been for more than seventy-five years.

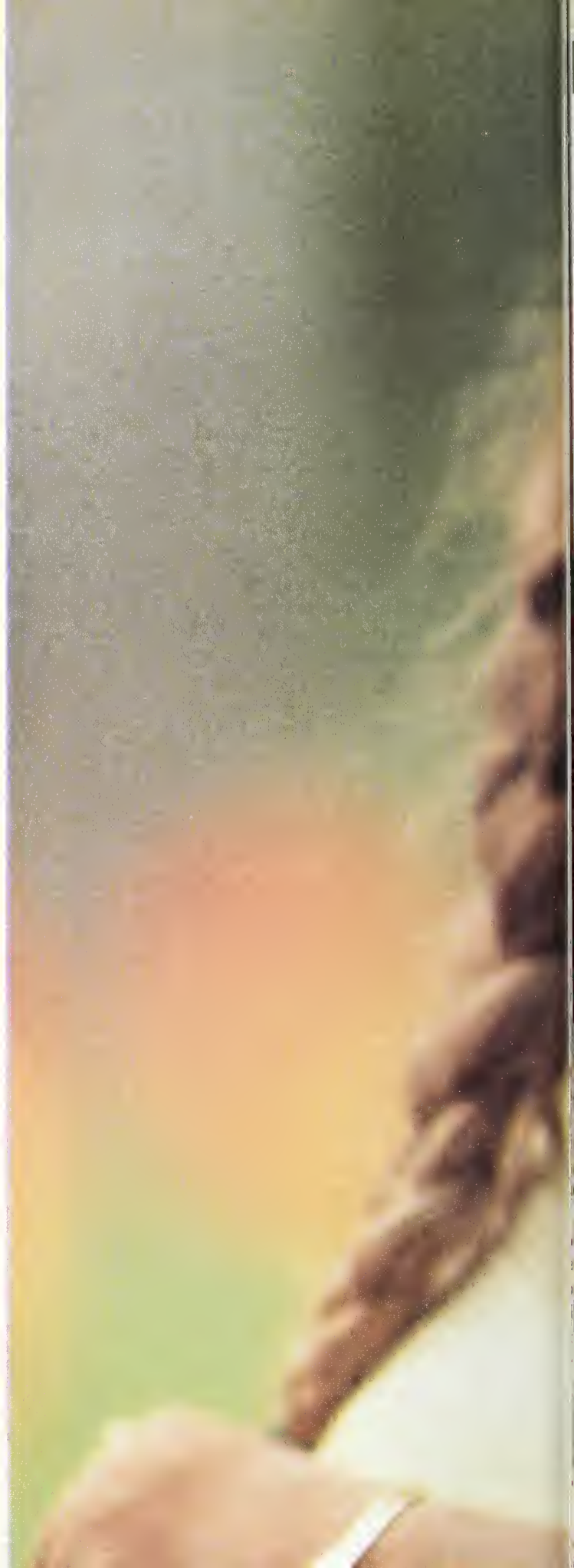
Recognized by all major insurance companies, Carrier is a private, non-profit psychiatric hospital providing both inpatient and outpatient programs. Some of Carrier's specialized programs include: addiction recovery service, adolescent program, affective disorders program, behavioral therapy, eating disorders program, family therapy, geriatric program and women's program.

For more information, call the Carrier Foundation at 1-800-223-0207. The Carrier Foundation. We're putting lives back together.



Carrier Foundation

Belle Mead, New Jersey 08502



Mohs Micrographic Surgery

MANUEL R. MORMAN, PhD, MD

Mohs micrographic surgery is an exacting technique used to treat difficult skin cancers by sequential excision of thin layers of tissues. This procedure produces a high cure rate, while sacrificing little normal tissue.

Cancer of the skin is the most common malignancy, with 400,000 to 500,000 new cases being diagnosed annually in the United States.¹ Basal cell cancer is the most common variety, comprising over 85 percent of all cutaneous malignancies with squamous cell cancer the next most common type. Although therapeutic modalities such as electrodesiccation and curettage, cryosurgery, surgical excision, and radiation are useful in treating skin cancers, some tumors will recur. These recurrent tumors, as well as primary tumors in some anatomical areas, or of a poorly defined extent, are best treated with a microscopically controlled technique.

Mohs micrographic surgery, known formerly as chemosurgery, is a surgical procedure for difficult skin cancers.² This technique involves the excision of the tumor in thin layers, with the excised tissue being carefully mapped, sectioned, and examined microscopically to determine lateral or deep invasion of the tumor beyond the margins of excision.

Dr. Morman is a clinical instructor in dermatology, UMDNJ-Robert Wood Johnson Medical School, New Brunswick. Requests for reprints may be addressed to Dr. Morman, 47 Orient Way, Rutherford, NJ 07070.

This process of mapping and sequential excision often is laborious but permits a precise removal of the tumor and sacrifice of very little normal tissue.³

HISTORICAL PERSPECTIVE

Mohs micrographic surgery was developed by Dr. Frederic Mohs at the University of Wisconsin in the late 1930s and early 1940s. He noted that when zinc chloride fixative was applied to the skin at the site of a tumor and excised, the skin maintained the histologic architecture just as if it had been put into a fixative solution. He developed a technique of cutting the excised, fixed tissue into smaller pieces and, with the use of colored dyes, mapping and orienting the tissue. This facilitated an accurate localization and eventual removal of the cancerous growth, far exceeding the results with any of the other modalities available.⁴

This zinc chloride technique, known as chemosurgery for over 30 years, essentially has been replaced by a tissue technique which uses no fixative. This "fresh" tissue technique is much faster, less painful, and just as accurate as the original chemosurgical technique. The cure rates are just as high; the cosmetic results, more satisfying.⁵

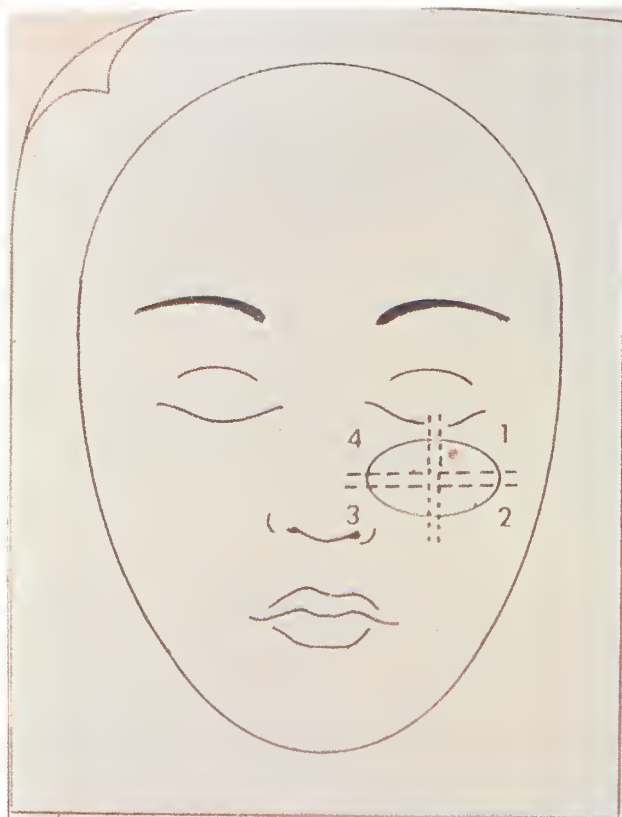


Figure 1. Schematic picture showing an excised layer of tissue subdivided into four color-coded pieces.

Table 1. Steps in the Mohs procedure.

- Identification and marking of the presumed area of tumor.
- Excision of a thick layer of tissue with a flat undersurface.
- Mapping, staining, and sectioning of all excised tissue.
- Microscopic examination and delineation of residual tumor.
- If necessary, excision of a second and possibly additional layers, until a tumor-free plane is reached.
- Healing by granulation and re-epithelialization or by surgical reconstruction.

PROCEDURE

Mohs surgery is performed in the outpatient setting under local anesthesia. The rare exceptions are for extremely large and deep tumors that might involve vital structures, or for patients with concurrent medical problems that might require careful monitoring of their medical condition.

The rough extent of the tumor is determined grossly by visual examination and palpation, and the border is indicated by a skin marker. The area is cleansed with betadine or hibiclens, and a local anesthetic such as 1 percent lidocaine with 1:150,000

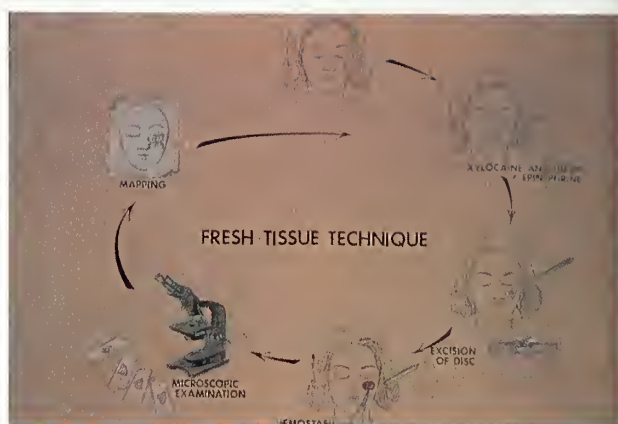


Figure 2. Diagram of steps followed during Mohs surgery. Following localization of the tumor and instillation of local anesthesia, the first fresh tissue layer is excised, subdivided, stained, and examined microscopically. Location of residual tumor, if any, is plotted and more tissue excised in a similar fashion.

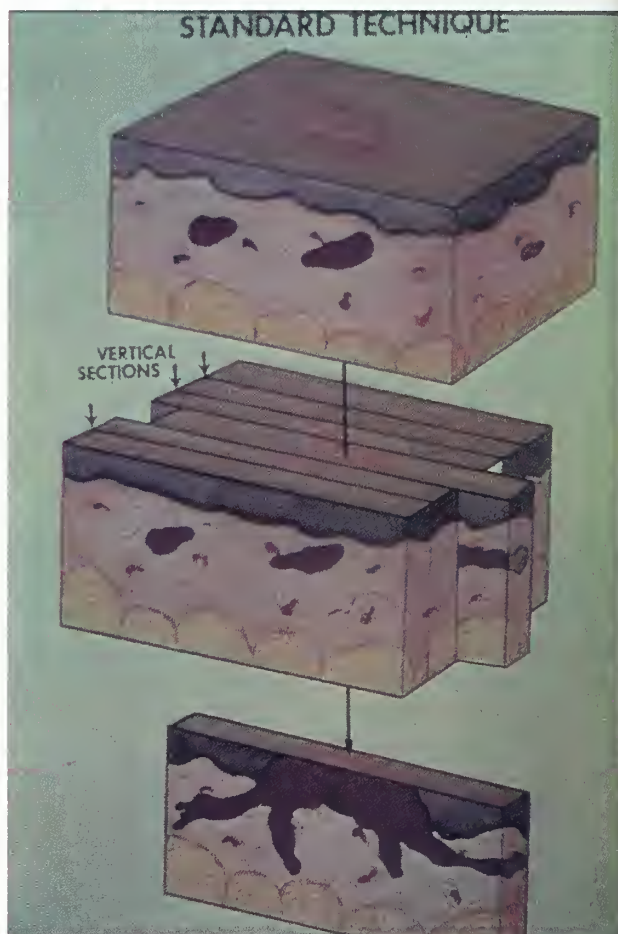


Figure 3. Illustration showing how vertical sectioning through excised tissue can result in residual tumor unless the section happens to be precisely where the tumor reaches the edge of the section; in vertical sectioning, outgrowths of tumor can be missed easily.

epinephrine administered around and beneath the area. After 20 minutes, the first fresh tissue layer is excised, taking all gross tumor and a small margin of normal-appearing tissue. Great care is taken to

insure a flat or saucerized undersurface, as this is essential for the accurate preparation of the frozen sections from the base of the specimen. Hemostasis is achieved using electrocoagulation, a hemostatic agent such as Oxycel® cotton or Gelfoam®, suture ligatures, or pressure alone. A temporary pressure dressing is placed over the wound until the tissue can be studied histologically.

At this point, the excised tissue is taken back to the laboratory, cut into smaller pieces, and each piece then is marked with various colors of ink so that each side has its own color. A map then is prepared of the excised tissue and its component

color-coded pieces. Each piece is subjected to frozen sectioning of the entire undersurface and lateral edges to locate any foci of tumor that go deeper or wider than the excision. If residual tumor is found, its location is marked on the map, which is used to direct the excision of the second layer (Figure 1).

Table 2. Indications for Mohs micrographic surgery.
• Recurrent tumors.
• Cancers in sites with a high risk for recurrence (nose, periorbital areas, ears, and scalp).
• Morpheaform basal cell cancer.
• Large tumors (greater than 2 cm in diameter).

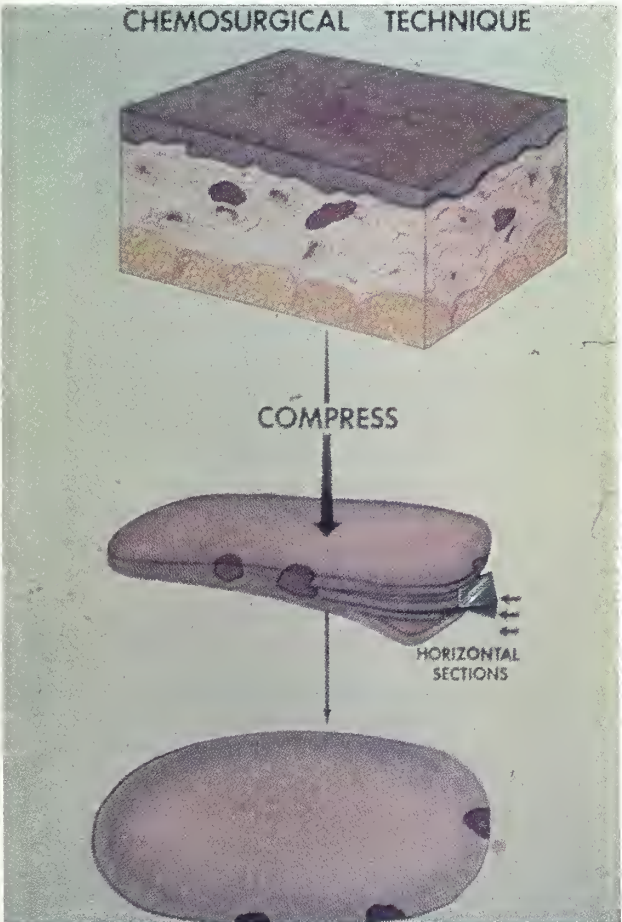


Figure 4. Illustration demonstrating the great advantage of horizontal sectioning. The flattened horizontal section permits easy visualization of the entire undersurface and edges of all the excised tissue.



Figure 5. Preoperative photograph of a recurrent cystic basal cell cancer on the dorsum and left side of the nose. This tumor had been treated on several occasions with electrodesiccation and curettage.



Figure 6. Micrographic diagrams prepared during surgery on patient in Figure 4. Areas marked with red pencil indicate residual areas of tumor.

The patient is returned to the operating table and a second layer taken, this excision being directed only at areas that are found to contain residual tumor. The procedure is continued until a tumor-free plane is reached (Figure 2).

When a tumor-free plane is achieved, the Mohs surgeon must decide on the best course of wound healing. Several options are open: granulation and re-epithelialization (healing by "second intention"); primary closure; or tissue rearrangement (flaps or grafts).

CASE REPORT

Figure 5 shows a large area of recurrent basal cell cancer on the nose of a 74-year-old female patient. The area had been treated on several occasions by electrodesiccation and curettage, but a further recurrence had prompted referral for Mohs surgery. Mohs surgery was done on an outpatient basis under local anesthesia, and residual tumor was found after several layers of fresh tissue surgery (Figure 6). After six layers, the tumor-free plane was reached and the resultant defect involved most of her nose and medial cheek area, and extended superiorly toward

both inner ocular canthi (Figure 7). In addition, tumor was found microscopically invasive into nasal cartilage but, luckily, not into bone. The decision was made to let this heal by second intention (Figure 8), and she did so in nine weeks in a fairly satisfactory manner except for a small perforation that eventually was repaired (Figure 9). She remains tumor-free after ten years.

The great majority of Mohs wounds are well suited for second intention healing. This eliminates any further surgery and also permits a more accurate inspection of the surgical site in the future. Primary closures and tissue rearrangement techniques are very useful in certain anatomical areas and also in patients where proper wound care during healing may present a problem.^{6,7}

A key to the appreciation of the high cure rates achieved with this technique (greater than 95 percent cure with recurrent tumors; 99 percent cure with primary tumors) is an understanding of the advantage of horizontal versus vertical sectioning. In the standard vertical sectioning of tissue, outgrowths of tumor could be easily missed (Figure 3). In the Mohs procedure, the sections are made horizontally,



Figure 7. Postoperative view of the final defect following surgery. Tumor was found to extend microscopically over most of the nose to involve the medial aspects of both cheeks and both inner canthal regions. Nasal cartilage was involved but not nasal bone.



Figure 8. Three-week postoperative view. Granulations and re-epithelialization have begun.



Figure 9. Four-month postoperative view. Re-epithelialization is complete. A small perforation into the left side of the nose exists and was closed subsequently.

Table 3. Advantages of Mohs micrographic surgery.

- Primary tumors have cure rate of greater than 99 percent.
- Recurrent tumors have cure rate of greater than 95 percent.
- Conservatism: only tumor is removed with little normal tissue.
- Low morbidity and mortality: no operative risk from general anesthesia.
- Low long-term costs (fewer recurrences).

Table 4. Disadvantages of Mohs micrographic surgery.

- Requires expertise by the treating physicians, histology technician, and nursing staff.
- Needs a histology laboratory for frozen section preparation.
- Time consuming.
- Increased short-term costs (more expensive than other modalities).

cutting through the entire undersurface (Figure 4). This permits a much easier and accurate visualization of the excised tissue.

DISCUSSION

Mohs micrographic surgery remains the modality with the highest cure rates for skin cancer, with the added advantages of conserving tissue. Nevertheless, it is not indicated for all skin cancer, but should be reserved for the more troublesome lesions (Tables 1 to 4). Lesions that have recurred or have a high propensity for recurrence most ideally are suited for this form of surgery.⁸ Small or primary lesions have cure rates almost as high with the more standard and available modalities such as excision, curettage and electrodesiccation, cryosurgery, and radiation therapy.

The other advantages of the technique are low

morbidity and mortality and greatly reduced long-term costs. The disadvantages are primarily related to the shortage of Mohs units, requiring expertise by the physician, as well as a trained histology and nursing staff. Mohs surgery is done primarily by dermatologists with an additional year of training in Mohs surgery. However, other subspecialties such as otorhinolaryngology and oculoplastic surgery occasionally will perform the procedure. At present, there are over 20 training centers in the United States having fellowships in Mohs surgery, but this supply is far short of the great demand as skin cancer continues to become more common. In New Jersey, the occurrence of skin cancer is increasing dramatically, reaching almost epidemic proportions.

While the initial costs of the Mohs surgery are greater than standard treatment techniques, due to the laborious steps of the procedure, it often is cheaper and more gratifying to patients and third-party payors in the long run. For these reasons, Mohs surgery will continue to make advances and become more popular. Several former United States presidents have had this procedure performed on their skin cancers, and the technique continues to become more well known.

SUMMARY

Mohs micrographic surgery is a procedure used to treat recurrent or difficult skin cancers by the sequential removal of thin, saucerized layers of tissue. These excised layers are sectioned on a microtome and examined microscopically, and maps are prepared to delineate areas of residual tumor as well as normal, uninvolved tissue. Due to this microscopic control, cure rates are extremely high for basal and squamous cell cancers. Because the technique spares as much normal skin as possible, the wounds produced are well suited for healing by secondary intention alone or by surgical reconstruction. A further benefit of the technique is that almost all cases can be done under local anesthesia alone and in an outpatient setting as well. This results in less morbidity and greatly reduced cost. ■

REFERENCES

1. National Institutes of Health: *Incidence of Non-melanoma Skin Cancer in the U.S.* Publication No. NIH 82-2433. Washington, D.C., U.S. Government Printing Office, December 1981.
2. Swanson NA: Mohs surgery: Techniques, indications, applications, and the future. *Arch Dermatol* 119:761-773, 1983.
3. Mohs FE: Chemosurgery: A microscopically controlled method of cancer excision. *Arch Surg* 42:279-295, 1941.
4. Mohs FE: Chemosurgical treatment of cancer of the skin: A microscopically controlled method of excision. *JAMA* 138:564-574, 1948.
5. Tromovitch TA, Stegman SJ: Chemosurgery (Mohs): Fresh tissue techniques. *Arch Dermatol* 110:231-233, 1974.
6. Roenigk RK, Ratz JL, Beilin PL, Wheeland RG: Trends in the presentation and treatment of basal cell carcinomas. *J Dermatol Surg Oncol* 12:860-865, 1986.
7. Robins P, Pollack SV, Robinson JK: Immediate repair of wounds following operations by Mohs fresh-tissue technique. *J Dermatol Surg Oncol* 5:329-336, 1979.
8. Levine HL, Bailin PL: Basal cell carcinoma of the head and neck: Identification of the high-risk patient. *Laryngoscope* 90:955-961, 1980.

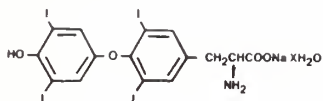
LEVOXINE®

(LEVOTHYROXINE SODIUM TABLETS, USP)

FOR ORAL ADMINISTRATION

DESCRIPTION:

Each LEVOXINE (Levothyroxine Sodium, USP) tablet contains synthetic crystalline levothyroxine sodium (L-thyroxine). L-thyroxine is the principal hormone secreted by the normal thyroid gland. Chemically, L-thyroxine is designated as L-tyrosine, 0-(4-hydroxy-3, 5-diiodophenyl) - 3,5-diiodo-L-tyrosine, monosodium salt, hydrate. The molecular formula is $C_{15}H_{10}I_4NNaO_4$ and the structural formula is:



CLINICAL PHARMACOLOGY:

The principal effect of thyroid hormones is to increase the metabolic rate of body tissues.

The thyroid hormones are also concerned with growth and development of tissues in the young.

The major thyroid hormones are L-thyroxine (T_4) and L-triiodothyronine (T_3). The amounts of T_4 and T_3 released from the normally functioning thyroid gland are regulated by the amount of thyrotropin (TSH) secreted from the anterior pituitary gland. T_4 is the major component of normal thyroid gland excretions and is therefore the primary determinant of normal thyroid functions. T_4 acts as a substrate for physiologic deiodination to T_3 in the peripheral tissues. The physiologic effects of thyroid hormones are mediated at the cellular level primarily by T_3 .

LEVOXINE (L-thyroxine) tablets taken orally provide T_4 which upon absorption can not be distinguished from T_4 that is secreted endogenously.

INDICATIONS AND USAGE:

LEVOXINE (L-thyroxine) tablets are indicated as replacement or supplemental therapy for diminished or absent thyroid function (e.g., cretinism, myxedema, nontoxic goiter or hypothyroidism generally, including the hypothyroid state in children, in pregnancy and in the elderly) resulting from functional deficiency, primary atrophy, from partial or complete absence of the gland or from the effects of surgery, radiation or antithyroid agents. Therapy must be maintained continuously to control the symptoms of hypothyroidism.

CONTRAINDICATIONS:

L-thyroxine therapy is contraindicated in thyrotoxicosis, acute myocardial infarction and uncorrected adrenal insufficiency.

WARNINGS:

Drugs with thyroid hormone activity, alone or together with other therapeutic agents, have been used for the treatment of obesity. In euthyroid patients, doses within the range of daily hormonal requirements are ineffective for weight reduction. Larger doses may produce serious or even life-threatening manifestations of toxicity, particularly when given in association with sympathomimetic amines such as those used for their anorectic effects.

PRECAUTIONS:

General — Caution must be exercised in the administration of this drug to patients with cardiovascular disease. Development of chest pains or other aggravation of the cardiovascular disease requires a reduction of dosage.

Information For The Patient — Patients on thyroid preparations and parents of children on thyroid therapy should be informed that:

1. Replacement therapy is to be taken essentially for life, with the exception of cases of transient hypothyroidism, usually associated with thyroiditis, and in those patients receiving a therapeutic trial of the drug.
2. They should immediately report during the course of therapy any signs or symptoms of thyroid hormone toxicity, e.g., chest pain, increased pulse rate, palpitations, excessive sweating, heat intolerance, nervousness, or any other unusual event.
3. In case of concomitant diabetes mellitus, the daily dosage of antidiabetic medication may need readjustment as thyroid hormone replacement is achieved. If thyroid medication is stopped, a downward readjustment of the dosage of insulin or oral hypoglycemic agent may be necessary to avoid hypoglycemia. At all times, close monitoring of urinary glucose levels is mandatory in such patients.
4. In case of concomitant oral anticoagulant therapy, the prothrombin time should be measured frequently to determine if the dosage of oral anticoagulants is to be readjusted.
5. Partial loss of hair may be experienced by children in the first few months of thyroid therapy, but this is usually a transient phenomenon and later recovery is usually the rule.

Laboratory Tests — The patient's response to thyroid replacement may be followed by laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels.

Drug Interactions — In patients with diabetes mellitus, addition of thyroid hormone therapy may cause an increase in the required dosage of insulin or oral hypoglycemic agents. Therefore, patients with diabetes mellitus should be observed closely for possible changes in antidiabetic drug dosage requirements.

Patients stabilized on oral anticoagulants who are found to require thyroid replacement therapy should be watched very closely when therapy is started. If a patient is truly hypothyroid, it is likely that a reduction in anticoagulant dosage will be required. No special precautions appear to be necessary when oral anticoagulant therapy is begun in a patient already stabilized on maintenance thyroid replacement therapy.

Cholestyramine binds both T_4 and T_3 in the intestine, thus impairing absorption of these thyroid hormones. In vitro studies indicate that the binding is not easily removed. Therefore, four to five hours should elapse between administration of cholestyramine and thyroid hormones.

Estrogens tend to increase serum thyroxine-binding globulin (TBG). In a patient with a non-functioning thyroid gland who is receiving thyroid replacement therapy, free thyroxine may be decreased when estrogens are started thus increasing thyroid requirements. However, if the patient's thyroid gland has sufficient function the decreased free thyroxine will result in a compensatory increase in thyroxine output by the thyroid. Therefore, patients without a functioning thyroid gland who are on thyroid replacement therapy may need to increase their thyroid dose if estrogens or estrogen containing oral contraceptives are given.

Drug/Laboratory Test Interactions — The following drugs or moieties are known to interfere with laboratory tests performed on patients taking thyroid hormone: androgens, corticosteroids, estrogens, oral contraceptives containing estrogens, iodine-containing preparations, and the numerous preparations containing salicylates.

1. Changes in TBG concentration should be taken into consideration in the interpretation of T_4 and T_3 values. In such cases, the unbound (free) hormone should be measured. Pregnancy, estrogens, and estrogen-containing oral contraceptives increase TBG concentrations. TBG may also be increased during infectious hepatitis. Decreases in TBG concentrations are observed in nephrosis, acromegaly, and after androgen or corticosteroid therapy. Familial hyper- or hypo-thyroxine-binding-globulinemias have been described. The incidence of TBG deficiency approximates 1 in 9000. The binding of thyroxine by thyroid-binding prealbumin (TBPA) is inhibited by salicylates.

2. Medical or dietary iodine interferes with all in vivo tests of radio-iodine uptake, producing low uptakes which may not be reflective of a true decrease in hormone synthesis.

3. The persistence of clinical and laboratory evidence of hypothyroidism in spite of adequate dosage replacement indicates either poor patient compliance, poor absorption, excessive fecal loss, or inactivity of the preparation. Intracellular resistance to thyroid hormone is quite rare.

Carcinogenesis, Mutagenesis, And Impairment

Of Fertility — A reportedly apparent association between prolonged thyroid therapy and breast cancer has not been confirmed and patients on thyroid for established indications should not discontinue therapy. No confirmatory long-term studies in animals have been performed to evaluate carcinogenic potential, mutagenicity, or impairment of fertility in either males or females.

Pregnancy — Category A — Thyroid hormones do not readily cross the placental barrier. The clinical experience to date does not indicate any adverse effect on fetuses when thyroid hormones are administered to pregnant women. On the basis of current knowledge, thyroid replacement therapy to hypothyroid women should not be discontinued during pregnancy.

Nursing Mothers — Minimal amounts of thyroid hormones are excreted in human milk. Thyroid is not associated with serious adverse reactions and does not have a known tumorigenic potential. However, caution should be exercised when thyroid is administered to a nursing woman.

Pediatric Use — Pregnant mothers provide little or no thyroid hormone to the fetus. The incidence of congenital hypothyroidism is relatively high (1:4,000) and the hypothyroid fetus would not derive any benefit from the small amounts of hormone crossing the placental barrier. Routine determinations of serum (T_4) and/or TSH is strongly advised in neonates in view of the deleterious effects of thyroid deficiency on growth and development.

Treatment should be initiated immediately upon diagnosis, and maintained for life, unless transient hypothyroidism is suspected, in which case, therapy may be interrupted for 2 to 8 weeks after the age of 3 years to reassess the condition. Cessation of therapy is justified in patients who have maintained a normal TSH during those 2 to 8 weeks.

ADVERSE REACTIONS:

Adverse reactions are due to overdosage and are those of induced hyperthyroidism.

OVERDOSAGE — Excessive dosage of thyroid medication may result in symptoms of hyperthyroidism. Since, however, effects do not appear at once, the symptoms may not appear one to three weeks after the dosage regimen is begun. The most common signs and symptoms of overdosage are weight loss, palpitation, nervousness, diarrhea or abdominal cramps, sweating, tachycardia, cardiac arrhythmias, angina pectoris, tremor, headache, insomnia, intolerance to heat and fever. If symptoms of overdosage appear, discontinue medication for several days and reinstitute treatment at a lower dosage level.

Laboratory tests such as serum T_4 , serum T_3 and the free thyroxine index will be elevated during the period of overdosage.

Complications as a result of the induced hypermetabolic state may include cardiac failure and death due to arrhythmia or failure.

TREATMENT OF OVERDOSAGE — Dosage should be reduced or therapy temporarily discontinued if signs of symptoms of overdosage appear. Treatment may be reinstituted at a lower dosage. In normal individuals, normal hypothalamic-pituitary-thyroid axis function is restored in 6 to 8 weeks after thyroid suppression.

Treatment of acute massive thyroid hormone overdosage aimed at reducing gastrointestinal absorption of the drugs is a counteracting central and peripheral effects, mainly those increased sympathetic activity. Vomiting may be induced initially if further gastrointestinal absorption can reasonably be prevented and barring contraindications such as coma, convulsions, loss of the gagging reflex. Treatment is symptomatic and supportive. Oxygen may be administered and ventilation maintained. Cardiac glycosides may be indicated if congestive heart failure develops. Measures to control fever, hypoglycemia, or fluid loss should be instituted if needed. Antiadrenergic agents, particularly propranolol, have been used advantageously in the treatment of increased sympathetic activity. Propranolol may be administered intravenously at a dosage of 1 to 3 mg over a 10 minute period, orally, 80 to 160 mg/day, especially when no contraindications exist for its use.

DOSAGE AND ADMINISTRATION:

The goal of therapy should be the restoration of euthyroidism, judged by clinical response and confirmed by appropriate laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels. The age and general condition of the patient and the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage.

In otherwise healthy adults, the recommended initial dose is 25 to 100 mcg (0.025 to 0.1 mg) daily, while the predicted maintenance dose of 100 to 200 mcg (0.1 to 0.2 mg) daily may be achieved in two to three weeks.

In the elderly patient with long standing disease, evidence of myxedema, or evidence of cardiovascular dysfunction, the initial dose may be as little as 12½ mcg (0.0125 mg) per day. Incremental increases of 25 mcg (0.025 mg) per day at 3 to 4 week intervals may be instituted depending on patient response. It is the physician's judgement of the severity of the disease and close observation of patient response which determine the rate and extent of dosage increase.

In infants and children there is a great urgency to achieve thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult. The recommended daily replacement dosage of L-thyroxine in childhood is: 0-1 years: 5-6 mcg/kg; 1-5 years: 3-5 mcg/kg; 6-12 years: 4-5 mcg/kg of body weight daily.

DOSAGE FORMS AVAILABLE:

LEVOXINE (L-thyroxine) tablets are supplied as oval, coded, potency marked tablets in eleven strengths: 12½ mg (0.0125 mg)—maroon, 25 mcg (0.025 mg)—orange, 50 mg (0.05 mg)—white, 75 mcg (0.075 mg)—purple, 100 mcg (0.1 mg)—yellow, 112 mg (0.112 mg)—rose, 125 mcg (0.125 mg)—brown, 150 mcg (0.15 mg)—blue, 175 mcg (0.175 mg)—turquoise, 200 mcg (0.2 mg)—pink and 300 mcg (0.3 mg)—green, in bottles of 100, 1000, unit dose cartons of 100 (strips of 10 each), and 500 mcg injectable (See injectable package insert).

dp DANIELS
PHARMACEUTICALS, INC.

2517 25th Avenue North
St. Petersburg, Florida 33713-3999

Chronic Arsenicism

With Vitiligo, Hyperthyroidism, and Cancer

LYNN K. BICKLEY, MD
CHRISTOPHER M. PAPA, MD

Chronic arsenicism, which may result from medicinal administration of arsenic, can present typical cutaneous signs, and is associated with an increase in cutaneous and internal malignancies. Recognition of the cutaneous premalignant stigmata of chronic arsenicism can identify a patient at risk, and promote early detection and treatment of life-threatening cancers.

Chronic exposure to inorganic arsenic may occur from industrial, environmental, and medicinal sources. As recent as the middle of this century, various compounds containing arsenic were popular treatments for a variety of ailments. Unfortunately, large cumulative doses of arsenic have been found to place patients at greatly increased risk for skin cancer and have been implicated in the development of several internal malignancies.¹ Patients subjected to chronic arsenic intoxication can develop characteristic dermatologic findings that should alert the physician to the possibility of cutaneous and internal cancer.

Dr. Bickley is chief resident, dermatology, UMDNJ-New Jersey Medical School, Newark, and Dr. Papa is clinical professor of medicine, Department of Dermatology, UMDNJ-Robert Wood Johnson Medical School, New Brunswick. Requests for reprints may be addressed to Dr. Bickley, 715 Edison Glen Terrace, Edison, NJ 08837.

We present a patient who exhibited various manifestations of chronic arsenicism, including cutaneous arsenical keratoses, squamous cell carcinomas of the extremities and vulva, and internal malignancy. In addition, our patient developed vitiligo and hyperthyroidism, two diseases of presumed autoimmune pathogenesis, which may affect the expression of malignancy.

CASE REPORT

In 1986, a 66-year-old black woman attended the Skin Cancer/Melanoma Screening Program at Robert Wood Johnson University Hospital. She was concerned about nonhealing ulcers of the feet that had developed and rapidly enlarged over the past month. On physical examination, a well-demarcated, moderately deep, nonpurulent, 2.0 x 1.8 cm ulceration was present on the right plantar surface, with a 1.1 x 0.8 cm similar lesion on the left plantar skin. The

surfaces of both palms and soles were studded with multiple, discrete, 0.2-0.4 cm, hard, horny papules that seemed embedded within shallow depressions (Figure 1). Multiple depigmented macules and patches of vitiligo were present on the distal extremities and face (Figure 2). There was a diffuse nonscarring alopecia on the scalp. No adenopathy was appreciated. The clinical diagnoses of squamous cell carcinoma of the soles and arsenical keratoses of the palms and soles were confirmed histologically.

An inquiry into possible arsenic exposure revealed the patient had been treated as a teenager with a clear, bitter liquid, felt to be Fowler's solution (potassium arsenite 1 percent). This medicine had been prescribed for the treatment of either asthma or rheumatic fever, at a dose of 4 drops, three times daily, for four years, resulting in an approximate cumulative dosage of 8.8 gm of arsenic. No additional history of arsenic exposure was elicited.

The past medical history of this patient is remarkable for hyperthyroidism, treated at age 26 with partial thyroidectomy, and for the development of depigmented patches of vitiligo on the extremities, head, and neck at age 31. By age 59, laryngeal carcinoma had occurred and was treated with irradiation, and a squamous cell carcinoma was excised from the right index finger. At this time, the patient first noted the development of arsenical keratoses. At age 65, six months prior to the onset of the plantar cancers, a radical vulvectomy and bilateral inguinal node dissection was performed for squamous cell carcinoma of the vulva. Following this surgery, she experienced severe hair loss with subsequent modest regrowth. In addition, she now suffers from mild asthma and hypertension. Her history is remarkable for thyroid disease in a sister; there is no known history of vitiligo or malignancy.

COURSE AND MANAGEMENT

The plantar squamous cell carcinomas were excised using the Moh's micrographic surgical technique, with good cosmetic and functional result. In an effort to prevent further development of skin cancer, and to modify the keratotic lesions, the patient applied tretinoin 0.1 percent cream (RETIN-A™) to one sole, and fluorouracil 5 percent cream (Efudex®) to the other sole. The hand used to apply both creams responded with softening and disappearance of the keratoses, while the individual applications did little for the plantar lesions. A regimen using the tretinoin cream at night and the fluorouracil cream in the morning successfully decreased the size and number of arsenical keratoses, and for 18 months, no new squamous cell cancers developed. The patient then was lost to followup for 6 months, during which time therapy had been dis-

Arsenic. An element, a steel-gray metal, symbol As, atomic no. 33, atomic weight 74.9; forms a number of poisonous compounds, some of which are used in medicine.

continued. She returned with a 1.5 cm ulcerated squamous cell carcinoma on the left lateral plantar skin (Figure 3), a 1.0 cm cancer on the dorsal right great toe, and similar cancers on the thumbs, along with recurrence of the keratoses. The new cancers were removed with curettage and electrofulguration, and treatments with tretinoin and fluorouracil have been resumed.

DISCUSSION

Arsenic compounds, which have been employed in the medical treatment of many diseases, first were reported to be associated with malignancy by Hutchinson in 1888.² Despite his observations, arsenic in the form of Fowler's solution and "Asiatic pills" continued to be a popular therapy for many conditions, including asthma, epilepsy, and various dermatoses. Over the years, reports of the carcinogenicity of arsenic appeared, and in 1975, a selected review concluded that 70.1 percent of those persons exposed to inorganic trivalent arsenic developed skin cancer and 6.3 percent had internal cancer.¹ Subsequent epidemiologic data confirmed that arsenic can cause skin and lung cancer, and suggested a role in other malignancies.³ With this knowledge and the emergence of a vast therapeutic armamentarium, modern medicine essentially has abandoned arsenic, so that environmental and industrial exposures have become more likely sources of arsenic intoxication today. Nevertheless, the cohort of patients treated with arsenic in the past now may be presenting with the long-term sequelae of the therapy.

Chronic cutaneous arsenicism is characterized by keratoses, hyperpigmentation, and skin cancer. In a study of patients treated with Fowler's solution for extended periods, at least one of these three findings was present in approximately half of the patients examined.⁴ The arsenical keratoses are small, yellow to flesh-colored papules present in variable numbers, commonly on the palms and soles in pressure-bearing areas. There is a median of 24 years between onset of arsenic therapy and appearance of the keratoses.¹ Unlike punctate keratoderma of the palms and soles, an autosomal dominant condition that may be confused with arsenical keratoses, re-

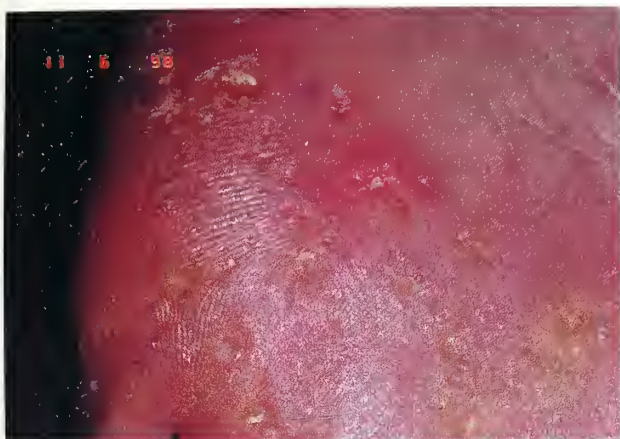


Figure 1. Arsenical keratoses, typical of those that studded the palmar and plantar skin, as shown on our 66-year-old patient at the screening program. Most of these cleared with topical tretinoin and fluorouracil therapy.

removal of the keratotic plug from an arsenical keratosis does not leave behind a pit in the skin.⁵ Histologically, the arsenical keratosis shows hyperkeratosis, acanthosis, and variable parakeratosis, while cellular atypia may or may not be present.⁶

The hyperpigmentation of chronic arsenic intoxication occurs in non-sun exposed areas, and can be more pronounced in intertriginous and pressure-bearing areas. It either may be diffuse or raindrop-like, with small, normally pigmented macules appearing among areas of hyperpigmentation.

Other cutaneous manifestations of chronic arsenicism include hyperkeratosis and desquamation of the skin, patchy or diffuse alopecia, and localized edema. In addition, the nails may be brittle and exhibit transverse white bands, known as Aldrich-Mee's lines.⁷

The relationship between arsenic and cutaneous malignancy is well established and the incidence of keratoses and skin cancer increases with increasing dosage of the arsenic.¹ The cutaneous malignancies associated with arsenic are Bowen's disease (carcinoma in situ), squamous cell carcinoma, and basal cell carcinoma. The squamous cell carcinomas may develop from arsenical keratoses, presumably those exhibiting more pronounced atypia, or from lesions of Bowen's disease, which arise *de novo* as red, scaly papules or plaques. If Bowen's disease should present on a patient's non-sun exposed skin, or in black patients, one should consider the possibility of arsenic exposure.⁵ The basal cell carcinomas that develop after arsenic exposure usually are multiple and superficial, and may be located anywhere on the body.

While the association between chronic arsenic intoxication and skin cancer is strong, the increased risk of internal malignancy after arsenic exposure is suspected, but not absolutely proved. Arsenic has



Figure 2. Vitiligo, shown on the right hand, was present primarily on the extremities and face. Shortening and scarring of the index finger resulted from prior excision of a squamous cell carcinoma.



Figure 3. Squamous cell carcinoma of the left foot, occurring several months after topical therapy was discontinued. Arsenical keratoses and vitiligo also are obvious.

been implicated in many cancers, including that of the gastrointestinal, respiratory, and urinary tracts,⁸ the hepatic vasculature,⁹ the nasopharynx,¹⁰ and the hematopoietic system.¹¹ In the previously cited study of patients treated with arsenic, every patient who died from cancer had pre-existing keratoses or hyperpigmentation, suggesting that cutaneous stigmata may portend a higher risk of internal malignancy.⁴ The long latency period for carcinogenicity, individual variability, and the frequency of cancer in the general population, all likely confound the effort to establish a statistical link between arsenic and internal malignancy.

The patient we report supports the contention that arsenic can cause internal cancer. She ingested an estimated 8.8 gm of potassium arsenite over a 4-year period; after a 40-year latent period, she had extensive arsenical keratoses, multiple squamous cell carcinomas, and an internal malignancy.

This patient is particularly interesting in that she

showed widespread vitiligo and not the hyperpigmentation typical of arsenicism. While the etiology of vitiligo is not certain, an autoimmune pathogenesis has been proposed, and it has been associated with many autoimmune diseases.¹² The most frequently associated disorder is thyroid disease, which may be seen in up to 30 percent of vitiligo patients, and which was present in our patient.¹³ A chemical leukoderma, very similar to vitiligo, may result from exposure to compounds such as phenols, hydroquinones, and thiotepea.¹² Arsenic has not been established as a cause of such a leukoderma; however, in one study of arsenic intoxication in Hungary, a 3 percent prevalence of vitiligo was felt to be partially associated with arsenic.¹⁴ Autopsy findings from a few patients with chronic arsenic intoxication have included a nodular goiter and a slight nodular alteration of the thyroid, but thyroid disease is not typical in chronic arsenicism.⁸

In our patient, it is likely that there is an etiological relationship between her vitiligo and hyperthyroidism, while it is uncertain that these disorders are a consequence of arsenic exposure. The co-existing autoimmune diseases, however, may play an important role in explaining the patient's particular predilection towards epithelial neoplasms. Vitiligo has been associated with several internal malignancies and a study of natural killer (NK) cell-mediated cytotoxicity against a certain malignant cell line has demonstrated decreased activity of the NK cells from vitiligo patients.¹⁵ It is conceivable that a more permissive state exists in our patient with vitiligo, thereby enhancing malignancy.

Management of the patient with chronic

arsenicism consists primarily of vigilance, with prompt removal of developing neoplasia. The arsenic that was ingested does not remain in the tissues, but presumably causes some cellular change that results in the keratoses and neoplasia.¹ Thus, there is little rationale in attempting to remove residual arsenic using agents such as dimercaprol. The aromatic retinoid etretinate has been found to be helpful in clearing arsenical keratoses and improving Bowen's disease, however, basal cell carcinomas rapidly recur after the retinoid is discontinued, and squamous cell carcinomas do not respond at all.¹⁶ In addition, long-term systemic retinoid therapy with the currently available agents is not practical in light of numerous well-documented side effects, especially lipid abnormalities and skeletal toxicity.¹⁷ Topical therapy, using tretinoin and fluorouracil, was found to be safe and effective in treating precancerous arsenical keratoses in our patient, although continuous prophylactic therapy appears to be needed.

It is probable that other persons still alive in New Jersey have chronic arsenicism as a result of outmoded medical treatments. With this in mind, an attempt was made to obtain the old medical records of our patient. None could be located, and thus, there is no starting point from which to seek out other at-risk individuals. This report may serve to remind clinicians throughout the state of the association between the typical cutaneous clues of chronic arsenicism and the increased risk of malignancy, and to highlight the need to inquire about past exposures to arsenic. Increased surveillance and more timely interventions then would be available to these patients. ■

REFERENCES

1. Jackson R, Grainge JW: Arsenic and cancer. *Can Med Assoc J* 113:396-401, 1975.
2. Hutchinson J: Arsenic cancer. *Br Med J* 2:1280, 1887.
3. Pershagen G: The carcinogenicity of arsenic. *Environ Health Perspect* 40:93-100, 1981.
4. Cuzick J, Evans S, Gillman M, et al.: Medicinal arsenic and internal malignancies. *Br J Cancer* 45:904-910, 1982.
5. Schwartz RA: Arsenical keratoses, in Schwartz RA (ed), *Skin Cancer Recognition and Management*. New York, NY, Springer-Verlag, 1988, pp. 11-13.
6. Yeh S: Skin cancer in chronic arsenicism. *Human Pathol* 4:469-485, 1973.
7. Schoolmeester WL, White DR: Arsenic poisoning. *South Med J* 73:198-208, 1980.
8. Sommers SC, McManus RG: Multiple arsenical cancers of skin and internal organs. *Cancer* 6:347-359, 1953.
9. Falk H, Herbert JT, Edmonds L, et al.: Review of four cases of childhood hepatic angiosarcoma-elevated environmental arsenic exposure in one case. *Cancer* 47:382-391, 1981.
10. Prystowsky SD, Elfenbein GJ, Lamberg SI: Nasopharyngeal carcinoma associated with long-term arsenic ingestion. *Arch Dermatol* 114:602-603, 1978.
11. Kjeldsberg CR, Ward HP: Leukemia in arsenic poisoning. *Ann Intern Med* 77:935-937, 1972.
12. Bolognia JL, Pawelek JM: Biology of hypopigmentation. *J Am Acad Dermatol* 19:217-255, 1988.
13. Cunliffe WJ, Hall R, Newell DJ, et al.: Vitiligo, thyroid disease, and autoimmunity. *Br J Dermatol* 80:135-139, 1968.
14. Nagy G, Korom I: Late skin symptoms of arsenic poisoning-observations in arsenic endemy at Bugac-Alsomonostor. *Z Hautkr* 58:961-964, 1983.
15. Ghoneum M, Grimes PE, Gill G, et al.: Natural cell-mediated cytotoxicity in vitiligo. *J Am Acad Dermatol* 17:600-605, 1987.
16. Thianprasit M: Chronic cutaneous arsenism treated with aromatic retinoid. *J Med Assoc Thai* 67:96-100, 1984.
17. Ellis CN, Voorhees JJ: Etretinate therapy. *J Am Acad Dermatol* 16:267-291, 1987.

Xeroderma Pigmentosum

W. CLARK LAMBERT, MD, PhD

Xeroderma pigmentosum is a rare, recessively inherited, sun-sensitive disorder with a defective DNA repair mechanism that is the best model currently available linking human cancer to exposure to a specific carcinogen. Laboratory and epidemiological studies of this disease are providing extensive insight into the etiology of cancer in the general population.

Xeroderma pigmentosum is a recessively inherited disease in which affected individuals are abnormally sensitive, often exquisitely so, to ultraviolet light in wavelengths present in ordinary sunlight. As a result, patients experience erythema (redness), which may be severe, of their skin in exposed areas following mild sun

exposure. Longer exposure produces changes resembling severe sunburn, in doses which in normal persons would not even produce a slight tan. Subsequently, changes resembling those seen in elderly, fair-complexioned persons after many years of intense sun exposure may be seen (Figures 1 and 2). These changes, however, occur in xeroderma pigmentosum in childhood. They consist of superficial atrophy, dryness (xerosis or "xeroderma"), and pigmentary changes (pigmentosum, splotchy areas of hyperpigmentation, freckles, and irregular leukodermic areas). They do not develop the thickened dermal collagen ("elastic") seen in elderly persons. Later, solar (actinic) keratoses, squamous cell carcinomas, basal cell carcinomas, and mela-

Dr. Lambert is associate professor of pathology and medicine; director, Division of Dermatology and Department of Pathology; and vice-chairman, Division of Dermatology, UMDNJ-New Jersey Medical School, Newark. Correspondence may be addressed to Dr. Lambert, Room C-520, Medical Sciences Building, UMDNJ-New Jersey Medical School, 185 South Orange Avenue, Newark, NJ 07103-2757.



Figure 1. A teenage boy with xeroderma pigmentosum. Note the epidermal atrophy, areas of loss of tissue secondary to multiple surgical procedures, and marked pigmentary changes.

nomas develop in affected areas. Melanomas are a major problem and are the most common cause of death in these persons. Despite the careful followup that these patients often receive, melanomas sometimes are missed early in their course because of the difficulty in distinguishing them from the other irregularly shaped areas of hyperpigmentation seen in these patients. This is a major problem since melanomas have an excellent prognosis if recognized early, a less favorable one if recognized later, and a very poor one if recognized late.

Patients with xeroderma pigmentosum may acquire hundreds to thousands of skin malignancies during childhood, making management extremely difficult. Typically, the first patient in a family to present with this disease already has had enough light exposure as an infant to produce numerous skin tumors. Whether or not this is the case, early management is difficult. Protecting a patient from sunlight to the extent necessary in most cases of xeroderma pigmentosum is a formidable task, which becomes more difficult as the patient ages. A related problem is the fact that protection from sunlight to

the extent necessary to prevent sunburn probably is insufficient to prevent later development of cutaneous malignancies. If careful protection is carried out from birth, however, virtually complete lack of skin changes is the very rewarding result for the patient.

Eye changes in xeroderma pigmentosum, as well as photophobia, are an important finding in many patients, with severe conjunctival and corneal changes resembling those of the skin. In some patients, eye changes are not seen, however, and this is one of the numerous paradoxes regarding this disease. In most patients, eye protection during childhood involving the use of glasses that exclude ultraviolet (UV) light is an important facet of management. Malignancies of the anterior tongue, apparently due to the effect of sunlight, also occur in these patients.

While the aforementioned changes can be prevented by avoidance of sun exposure, some (but not all) patients with xeroderma pigmentosum also develop an additional clinical component which does not appear to be related to exposure to any particular etiologic agent. This important component is neurodegenerative disease. Thus, like amyotrophic lateral sclerosis, Alzheimer's disease, Werdnig-Hoffmann disease, and familial dysautonomia (the Riley-Day syndrome), xeroderma pigmentosum should be considered an example of a spontaneous neurodegenerative disease. Indeed, we and others have found evidence for defective DNA repair mechanisms in some of the neurodegenerative diseases; and there are several hypotheses relating defective DNA repair to the etiology of these disorders. The first neurological changes in xeroderma pigmentosum often are in sensory hearing loss of higher frequency sounds, an important aspect to follow in clinical management. Later, generalized deep tendon hyporeflexia may develop. This is a useful clinical sign in itself and also is a valuable aid in distinguishing xeroderma pigmentosum from an even rarer sun-sensitive condition, Cockayne's disease, in which hyporeflexia of deep tendon reflexes characteristically is found.

The incidence of xeroderma pigmentosum has been estimated at about 2 per million live births, but this is a gross estimate and the true incidence is unknown. It is much more common in Japan, Egypt, and North Africa than in other parts of the world, for reasons that are completely unknown. There is considerable heterogeneity in the clinical signs and severity of the disease, with some persons developing skin changes much later in life than others (Figure 2). Some of the reasons for this heterogeneity have been worked out on basis of worldwide laboratory research.

Xeroderma pigmentosum. Atrophoderma pigmentosum; angioma pigmentosum et atrophicum; an eruption of exposed skin occurring in childhood and characterized by numerous pigmented spots resembling freckles, larger atrophic lesions eventually resulting in glossy white thinning of the skin surrounded by telangiectases, and multiple solar keratoses which undergo malignant change at an early age; the condition results from a single-gene autosomal recessive disorder in which DNA repair processes are defective, with consequent hypersensitivity to the carcinogenic effect of ultraviolet light.*

*Stedman's Medical Dictionary, 24th Edition, 1982.

Biochemical studies on the etiology of xeroderma pigmentosum began approximately 20 years ago and it has become a pivotal laboratory model for study of diseases associated with DNA synthesis/repair or chromosome structural deficiencies. I now will summarize what is known about the etiology of this disease, and provide an understanding of why xeroderma pigmentosum is much more than just another rare genetic disease with an interesting biochemical deficiency.

In the early stages, xeroderma pigmentosum did appear to resemble other inherited diseases associated with a specific biochemical defect, although we now know this is incorrect. In 1968, James Cleaver, a biophysicist, on advice from a number of California dermatologists, notably Dr. John Epstein, showed that cultured fibroblasts from patients with this disease failed to show DNA repair-related unscheduled, i.e. outside of S phase, synthesis following exposure to ultraviolet light. Cells from normal persons show this unscheduled DNA synthesis, known as UDS, due to a repair mechanism in which damaged bases in DNA produced by ultraviolet light are excised by repair mechanisms and the excised strands of DNA filled in by new DNA synthesis. There are several possible ways in which this may occur, with different organisms shown to use one or more mechanisms; the initial step, is a single-stranded cleavage produced by a repair specific DNA endonuclease in the double-stranded DNA. An endonuclease is an enzyme that cuts a strand



Figure 2. A second patient with xeroderma pigmentosum. Note the atrophy, freckling, and other pigmentary changes. The lower severity of lesions, despite the fact that this individual is well into adulthood, is due to her being in a different complementation group than the patient in Figure 1. Note, also the hearing aid in this partially deaf individual.

of RNA or DNA, as contrasted with an exonuclease, which progressively digests, i.e. "chews up," a strand of DNA starting at one end. This is the enzyme that recognizes the actual damage; it is both the most critical and the rate-limiting step, and is the one that is defective in most cases of xeroderma pigmentosum.

At this point, classical biochemical genetics calls for isolating and then purifying the defective DNA endonuclease, then isolating and cloning the cDNA "gene" coding for this enzyme, using available computer matching sequences to find out whether any known sequence corresponds in whole or in part to the cDNA encoding the enzyme, and, finally, localizing the gene on the appropriate chromosome using nucleic acid hybridization techniques. However, xeroderma pigmentosum deviates from this scheme in a number of significant respects. First, there is no single defective endonuclease function, there are many. This has been shown by Dr. Dirk

Bootsma and his colleagues in Rotterdam. By fusing cells from different xeroderma pigmentosum patients in culture, and then performing UDS studies, they found that many of the fused cells (heterokaryons) showed normal or near normal levels of UDS, even though both cells if left unfused, showed markedly depressed UDS. Thus, each cell was supplying what the other was lacking in the heterokaryon. This showed the biochemical defect in the two cells was different, and, thus, the two patients from which they were obtained had two different generic deficiencies. By grouping patients with xeroderma pigmentosum whose cells in culture show depressed UDS and which fail or do not fail to complement each other to produce normal levels of UDS in heterokaryons, a total of nine different complementation groups labeled A-I, as well as a variant group whose cells show normal UDS, now have been identified. This considerably has clarified the clinical picture, with patients with lower sun-sensitivity and later onset skin lesions occurring in less severely affected complementation groups. In two complementation groups, Cockayne's disease has been found in every patient.

Second, although there is no doubt that, in all complementation groups of xeroderma pigmentosum, except the variant group, the major defect is in the endonuclease-mediated step, there is considerable evidence that activity of the endonuclease, itself, is not defective. Evidence from crude cell extracts incubated with purified DNA containing adducts has shown that xeroderma pigmentosum extracts can repair those adducts. However, if the damaged DNA is in the form of chromatin, repair by xeroderma pigmentosum cell extracts is not normal. Further work on these extracts has been hampered severely because normal DNA repair enzymes have proved to be extremely labile, rapidly losing activity as attempts at purification or storage proceed. In our laboratory, however, we have developed technology which allows these enzymes to be purified in active form. This technology is based mainly on developing techniques to store and process these chromatin-associated DNA repair enzymes at -20°C in liquid phase in purified ethylene glycol, rather than aqueous solvents.

Using these methods we now have shown that xeroderma pigmentosum cells indeed lack a factor which allows their ultraviolet endonuclease, which is normal, to interact with damaged DNA when in the form of chromatin. Introducing this factor back into cells restores normal DNA repair.

Third, using our system we have found several different defects within the same complementation group of xeroderma pigmentosum which was not anticipated. There are a number of other aspects of what now is known about xeroderma pigmentosum that are not consistent with classical Mendelian genetics: 1) the concurrence of xeroderma pigmentosum with Cockayne's disease in every patient in two complementation groups; 2) one family in complementation group A of xeroderma pigmentosum within which the disorder is transmitted by X-linked inheritance; and 3) finding a separate defect in natural-killer (NK) T-cells in two complementation groups of the disease. This has led us to propose a new type of genetics for this disease, co-recessive inheritance, in which one acquires the disease only if one is hemizygous or homozygous for defective alleles at more than one locus simultaneously. There now is a modest amount of evidence for this hypothesis, with more accumulating as more becomes known about xeroderma pigmentosum. The most important conclusion drawn from the co-recessive inheritance hypothesis is that carrier frequencies for these defective alleles are likely to be very high, affecting a very substantial proportion of the general population. Since these gene products protect against neoplasia, the high occurrence rate of defective genes proposed by the hypothesis may be a major factor in development of cancer, not just in close relatives of xeroderma pigmentosum patients, but in the general population.

Whatever the implications for DNA repair genes defective in xeroderma pigmentosum in the general population, it has become clear that the DNA repair proteins we are studying undergo complex but closely regulated interactions not unlike those of the complement, kinin, and coagulation cascades. Thus, we are on the threshold of an exciting new area of research in molecular pathobiology of both xeroderma pigmentosum and many other disorders. ■

REFERENCES

1. Lambert WC, Lambert MW: DNA repair deficiency and cancer in xeroderma pigmentosum. *Cancer Rev* 7:56-81, 1987.
2. Lambert WC, Andrews AD, German J, Kraemer KH: Xeroderma pigmentosum, in: Thiers BH, Dobson RL (eds), *Pathogenesis of Skin Diseases*. New York, NY, Churchill Livingstone, 1986, pp. 579-599.
3. Lambert WC, Lambert MW: Co-recessive inheritance: A model for DNA repair, genetic disease, and carcinogenesis. *Mutat Res* 145:227-234, 1985.
4. Lambert WC: Genetic diseases associated with DNA and chromosomal instability. *Dermatol Clin* 5:85-108, 1987.
5. Lambert WC: Xeroderma pigmentosum as a model for human carcinogenesis. *Cancer Invest* (in press).
6. Lambert WC: Diseases of DNA and chromosomal instability, in: Alpers J (ed), *The Genodermatoses*. Philadelphia, PA, W.B. Saunders (in press).

Dysplastic Nevi and Melanoma

SANDY S. MILGRAUM, MD
CHRISTOPHER M. PAPA, MD

Dysplastic nevi occur in individuals with an increased susceptibility to melanoma. Self-examination for new and changing lesions, avoidance of aggravating factors, and regular surveillance, permit early recognition, simple surgical excision, and cure of an otherwise fatal malignancy.

For the past 100 years, physicians have suspected that melanoma could arise from precursor lesions on the skin.¹ While a number of early reports mentions the presence of an increased number of moles or melanocytic nevi in

some patients with malignant melanoma, Clark and associates were the first to describe and study the association of distinctive, atypical nevi and familial melanoma.² In their 1978 report, they referred to these clinically histologically distinctive nevi in a setting of familial melanoma as the B-K mole syndrome (initials of the original patients). In 1980, Elder and colleagues reported the occurrence of the B-K mole phenotype outside of the familial melanoma setting.³ The term dysplastic nevus syndrome, familial or sporadic type, is in general use following agreement by a national consensus conference.⁴

1. **The Significance of Dysplastic Nevi.** Pa-

Dr. Milgraum is codirector, Melanoma-Pigmented Lesion Center and assistant clinical professor of pediatrics and medicine (dermatology), UMDNJ-Robert Wood Johnson Medical School. Dr. Papa is clinical professor of medicine (dermatology), UMDNJ-New Jersey Medical School, and guest editor of this issue. Requests for reprints may be addressed to Dr. Milgraum, UMDNJ-New Jersey Medical School, One Penn Plaza, New Brunswick, NJ 08901.

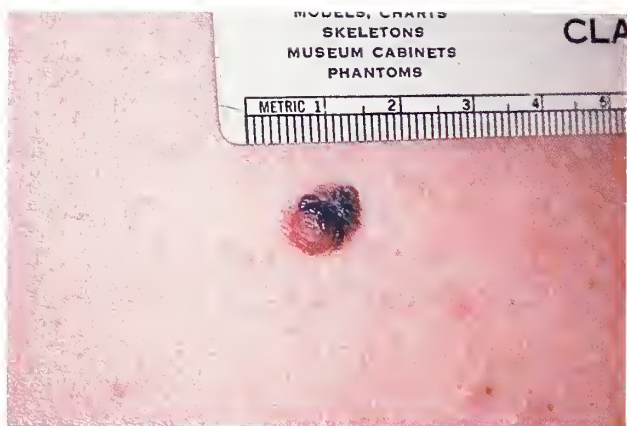


Figure 1. Histology confirmed a malignant melanoma at one pole of the tumor, while the other end, with the irregular brown macular extension was a typical dysplastic nevus.

tients with dysplastic nevi either may develop melanomas directly from these atypical moles (precursor lesions) (Figure 1) or the malignant tumors crop up on the normal appearing skin.⁵ Recognition of the changing moles, or newly formed suspicious lesions, allows surgical excision and complete cure.

Dysplastic nevi are common growths, occurring in 2 to 5 percent of the population.⁶ A portion of individuals with these lesions have them in a family setting, where other blood relatives also have dysplastic nevi, and melanomas. This autosomal dominant inheritance bestows the doubtful legacy of a 100 percent risk of developing a melanoma during a lifetime. Even patients with the sporadic type of dysplastic nevus, where there is no family history of these tumors, are estimated to be 26 times more likely to develop melanoma, than the general population.⁷ Discovering one patient with dysplastic nevi frequently uncovers an entire family of susceptibles. The effect is like dropping a pebble into still water, with ripples enveloping more and more at-risk individuals. A particularly gratifying experience is to learn of a geographically distant relative, who, acting on our patient's information, is discovered to have an early, operable melanoma.

2. Recognition of Dysplastic Nevi. It would seem a difficult task, at first glance, to be able to identify dysplastic nevi, since many people have so many common moles. The task is made easy by the differing appearance of the individual lesions, as well as contrasts in their distribution and behavior.

Although dysplastic nevi may be seen on infants and children, the abnormal moles behave more like their common counterparts during the early years. Both become more prominent with hormonal stimulation at puberty or with pregnancies. The melanocytic nevi darken and become palpable little tumors, transformed from flat brown spots. The dysplastic nevi, however, undergo a transformation of

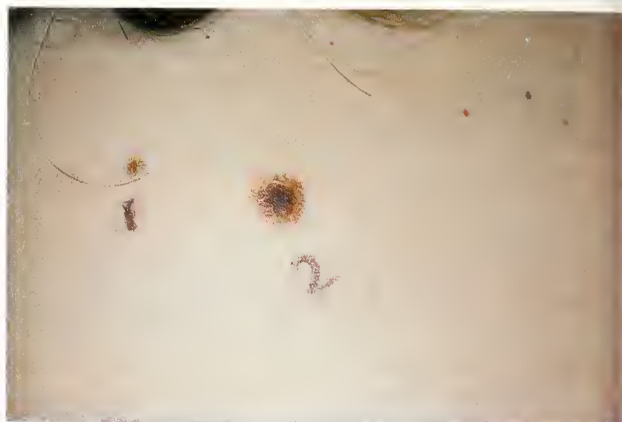


Figure 2. The "fried egg" appearance of a dark central portion surrounded by an irregular lighter brown halo is a common variety of dysplastic nevus.

shape, color, and size which is quite another thing. Moreover, while the common moles reach a 'steady state' in early adult life, and then gradually disappear over the years, the dysplastic nevi continue to arise throughout the lifetime.

An "ABCD Rule" can be used to contrast the abnormal moles from the more common variety (Figures 2, 3, and 4):

A. Asymmetry—Normal moles are regularly round or oval whereas the dysplastic nevi have irregular shapes.

B. Border—Melanocytic nevi have sharply margined, smooth borders, while the atypical tumors are indented, irregular, or fuzzy in outline.

C. Color—The common lesions are a homogenous brown color, be it light or dark, while dysplastic nevi are variegated with shades of brown, black, and red.

D. Diameter—The abnormal nevi are larger than the common moles, usually greater than 6 mm in diameter.

Dysplastic nevi generally are found on the upper torso and in covered sites (scalp, buttocks, and breasts) in contrast to melanocytic nevi which frequently occur on the upper extremities and face. The actual number of lesions is quite variable, from less than a dozen to over 100 or more.

The diagnosis of a dysplastic nevus finally is a histopathological one. The suspect lesion must be submitted to a competent dermatopathologist for confirmation. More often than not, the diagnosis will be confirmed. It particularly is difficult to distinguish between dysplastic nevi and superficial melanomas (Figure 5), which justifies the need to carefully select the largest, most atypical lesions for conservative, but complete, surgical excision, and pathological scrutiny. Dysplastic nevi should not be removed by shave biopsy as they have a tendency to recur.

3. Management. Once the diagnosis of dysplastic



Figure 3. This dysplastic nevus is asymmetrical, with a very irregular border, and a single, dark fleck of pigment within the tumor.



Figure 4. The clumped, irregular pigmentation and uneven outline, with a "bleeding" brown macular edge, mark this as a dysplastic nevus.

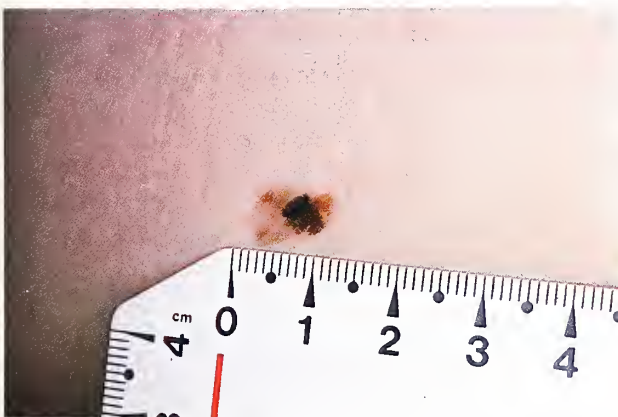


Figure 5. This very ominous looking lesion cannot be clinically differentiated from a superficial malignant melanoma. It was a nevus with severe dysplastic alterations.



Figure 6. Following sun exposure, the brown pigment of this irregular bordered dysplastic nevus moved to the central portion of the tumor, leaving a red rim about it.

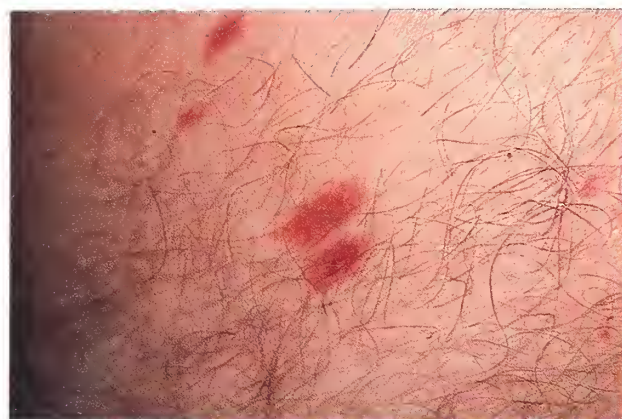


Figure 7. In many of the irradiated nevi, the brown pigment disappeared. The erythematous macules which remain still have the asymmetry and irregular border of the original tumor. Biopsy confirmed these as dysplastic nevi.

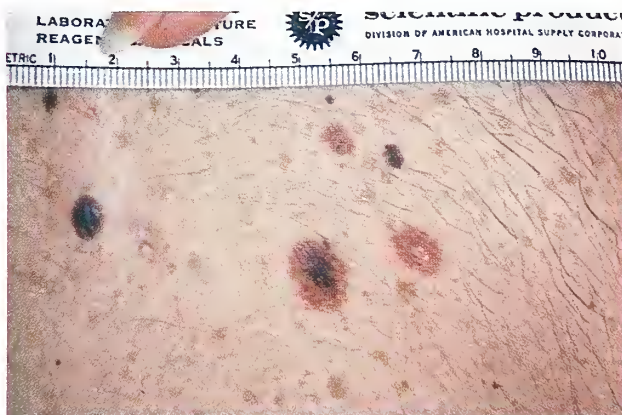


Figure 8. Dysplastic nevi in an AIDS patient. A variety of atypical lesions within one small area can be compared to the single, normal appearing melanocytic nevus on the left.

nevus is established, each patient receives a thorough briefing of its significance. Whether there are other family members with dysplastic nevi, or a history of melanoma in blood relatives, assumes great importance for the individual, as well as the family. Patients with the familial type of dysplastic

nevus syndrome, being at particular risk for the development of melanoma, receive more frequent physician surveillance. All patients are taught how to recognize the abnormal moles, and instructed in the method of self-examination of the skin. Two very good teaching aids are available from the National

Cancer Institute: a brochure entitled, "About Dysplastic Nevi," and a videotape with information in a simulated patient-physician interview. (The tape and a supply of the brochures may be obtained without cost.)

Those dysplastic nevi which are 6 mm or larger, and look to be the most atypical are excised, if there is a reasonably small number of tumors. Patients are asked to return quickly if new lesions develop or older tumors undergo change in shape, color, or size, at which time they may also be excised. Patients with more than 50 or so lesions present special problems since neither the patient nor physician can be expected to remember the location and characteristics of so many. Good color photography of body quadrants for orientation, and standardized closeups of the lesions is a daunting office procedure, and is expensive. Larger academic centers with full-time photographers which are capable of providing such services charge, as a minimum, \$200 for the basic photographs.⁸ These are projected on a large screen at revisit examinations and visually compared to the current lesions. It is not an easy or foolproof procedure. The newer video computer system developed at UMDNJ-Robert Wood Johnson Medical School (pages 401-403) has many advantages over the photograph method and will cost about the same to the patient. Patients are asked to return for a semi-annual examination, or sooner if there is concern.

PREVENTION

A unifying thread of gathering evidence suggests that suppression of cellular immunity enhances the development of most malignant tumors, including melanomas.⁹ Patients with dysplastic nevi are counseled to minimize activities which can predispose to cancer, maximize a healthy lifestyle, and be aware that extra surveillance is required if unavoidable immunosuppression occurs.

The simplest prescription is avoidance of

purposeful sun exposure, and the use of protective clothing and ultraviolet screening agents. One of our patients who unwisely suffered a sunburn had more than a score of his dysplastic nevi suddenly undergo rapid, alarming alterations.¹⁰ These reactive lesions began losing their brown pigment, with centripetal clumping of the color, leaving erythematous halos around the nevi, or completely changing red (Figures 6 and 7).

A more dramatic changing of dysplastic nevi occurred in another immunosuppressed patient, one with AIDS. While fighting opportunistic infections, his dysplastic nevi enlarged, became more irregular, darker, and bizarre (Figure 8). Since there is the possibility that the patients may encounter purposeful immunosuppression by physicians, they are informed to alert their doctor about the dysplastic nevi, and seek added, more frequent surveillance. A retrospective study of patients who developed melanoma after renal transplantation revealed that most had evidence of pre-existing dysplastic nevi.¹¹ We envision that increased use of chemotherapeutic drugs for nonmalignant conditions, e.g. methotrexate for psoriasis or rheumatoid arthritis, or chronic systemic corticosteroids for many diseases, may require greater vigilance. Women are seen every three months during pregnancies and the use of oral contraceptives is not encouraged.¹²

Ultimately, the best prevention rests with an educated, motivated patient. An important portion of each semiannual visit is devoted to reinforcing the patient's awareness of the atypical moles, reminding them of predisposing factors, inquiring about the family (newly discovered members are harbingers of bad news, increasing the patient's risk for melanoma), and, finally, encouraging continued self-examination and sun protection activities. With dysplastic nevus syndrome, the good efforts of both the physician and the patient are necessary in this congenial conspiracy to save lives. ■

REFERENCES

1. Solly E: Melanotic carcinoma and melanomata of doubtful character. *Trans Path Soc XX-XLI*: 315-316, 1890.
2. Clark WH Jr, Reimer RR, Greene MH, et al.: Origin of familial malignant melanomas from heritable melanocytic lesions. *Arch Dermatol* 114: 732-738, 1978.
3. Elder DE, Goldman LI, Goldman SC, et al.: Dysplastic nevus syndrome: A phenotypic association of sporadic cutaneous melanoma. *Cancer* 46: 1787-1794, 1980.
4. Precursors to malignant melanoma, consensus conference. *JAMA* 251: 1864-1866, 1984.
5. Greene MH, et al.: Acquired precursors of cutaneous malignant melanoma: The dysplastic nevus syndrome. *N Engl J Med* 312: 91-94, 1985.
6. Crutcher WA, Sagabiel RW: Prevalence of dysplastic nevi in a community practice. *Lancet II* 729, 1984.
7. Kraemer KH, Greene MH, Tarone R, et al.: Dysplastic nevi and cutaneous melanoma risk. *Lancet II* 1076-1077, 1983.
8. Slue W, Kopf A, Rivers J: Total body photograph of dysplastic nevi. *Lancet* 124:1239-1243, 1988.
9. Sunburn and melanoma. *Lancet I*: 1184, 1987.
10. Papa CM: Reactive dysplastic nevus syndrome. 25th Annual Meeting. Noah Worcester Dermatology Society, Key Biscayne FL, March 10, 1982.
11. Greene MH, et al.: Malignant melanoma in renal transplant recipients. *Lancet I*: 1196, 1981.
12. Holly EA, Weiss NS, Liff JM: Cutaneous melanoma in relation to exogenous hormones and reproductive factors. *J Natl Cancer Inst* 70:827-831, 1981.

Cutaneous T Cell Lymphoma

SOPHIE M. WOROBEK-VICTOR, MD

Cutaneous T cell lymphoma, also known as mycosis fungoides, is increasing in incidence in the United States. The author reviews its history, clinical presentation, diagnostic procedures, staging, prognosis, and therapy.

Cutaneous T cell lymphoma (CTCL), also known as mycosis fungoides, is a malignancy of T cell lymphocytes which originates in the skin. It is unique among lymphomas in that it readily is visible at a stage during which other lymphomas are nondetectable.

EPIDEMIOLOGY

The annual incidence of mycosis fungoides in the United States is projected at 7,500 to 10,000 cases, an incidence greater than that of Hodgkin's disease.¹ The annual incidence in the United States doubled between 1973 to 1984, from 0.19 to 0.42 cases per 100,000 population.² Prevalence in the United States

has been estimated at 40,000 to 50,000 cases. It is the only lymphoma to be more common in the black population than in the white population. Twice as many men as women are affected. Several studies in the United States have suggested that exposure to chemicals may play a contributory role in the development of CTCL. However, a recent case-controlled study on 53 mycosis fungoides patients in Scotland failed to show a statistically significant difference between the patients and control populations regarding such exposure.³

Interestingly, 6 of 11 patients in 1983, reported as having human type C retrovirus-associated adult T cell leukemia/lymphoma initially presented with cutaneous papular nodules, plaques, or erythroderma.⁴ This HTLV V-positive form of adult T cell lymphoma is associated with hypercalcemia, lytic

Requests for reprints may be addressed to Dr. Worobek-Victor, 280 Farmer Road, Bridgewater, NJ 08807.



Figure 1. Early CTCL shows as poorly outlined, superficial, scaly patches with admixed colors of pink, yellow, and violet (poikiloderma). The histology usually is nonspecific.

bone lesions, and rapid disease progression; and most frequently is found in Japan and among blacks from the West Indies and the southeastern United States.

HISTORY

Clendenning⁵ divides the history of this disease into three eras: the period from 1806 to 1940 in which the major clinical forms were recognized; the period from 1940 to 1970 with its gradual recognition that this disease is a single entity, a lymphoma, with variation in presentation and clinical course; and the present era of investigation into immunological mechanisms and optimal therapeutic management.

French dermatologists first recognized and catalogued the clinical characteristics of this disease. Jean Louis Alibert (1768-1838), founder of French dermatology, used the name "mycosis fungoides" in 1806 to report a case history in which a patient with a scaly rash later developed cutaneous "mushroom-like tumors." In 1870, Bazin described the progression of mycosis fungoides over months or years from a nonspecific dermatitis to disease with



Figure 2. "Poikiloderma atrophicans vasculare" describes the well-established, biopsy-proved, chronic phase of CTCL.

cutaneous plaques to tumor stage disease. In 1885, Vidal and Brocq described the tumeur d'emblee type of mycosis fungoides in which tumors suddenly appear without any preceding clinically apparent disease. By 1892, an erythrodermic variant was recognized by Besnier and Hallopeau. In 1938, Sézary and Bouvraïn reported that erythroderma can be associated with the dermal and peripheral blood presence of atypical "monstrous" mononuclear cells with redundantly folded nuclei.

From 1940 to 1970, there was debate on the relatedness of these various disease presentations, with the gradual recognition that they belonged to a single disease process with either a protracted nonaggressive "premycotic" course or clinically originating as the more aggressive forms of the "Sézary syndrome" type and the d'emblee type. In 1968, Lutzner and Jordan used electron microscopy to describe further the hyperchromatic and highly convoluted nucleus typical of the mononuclear cells first noted by Sézary and Bouvraïn, and as a result these cells acquired the eponym of "Lutzner cells."⁶

In 1973, Edelson and his coworkers demonstrated

that in mycosis fungoides, skin plaque and tumor infiltrates were composed of T lymphocytes.⁷ In the majority of cases, these cells are of the T helper subset, which "help" B lymphocytes in antibody production.⁸ Further studies in the 1970s gave evidence that visceral involvement was an extension of the cutaneous disease and not due to a separate lymphoreticular disease process. By 1978, an international workshop sponsored by the National Cancer Institute recommended that the term "cutaneous T cell lymphoma" (CTCL) be used for this disease.⁹

CLINICAL PRESENTATION

The classic or Alibert form of disease goes through three clinical stages: patch or premycotic stage; plaque (infiltrative) stage; and tumor (nodular) stage.

The earliest patch lesion is hypopigmented, or faint pink to red, macular, and eczematous, and tends to occur on the trunk and extremities. These early lesions can be single or multiple. They can be transient or respond to simple topical corticosteroid treatment and/or phototherapy. The histologic picture at this stage may be nonspecific or resemble that of benign dermatoses such as atopic eczema, contact dermatitis, psoriasis, seborrheic dermatitis, neurodermatitis, lichen planus, drug eruption, or pityriasis rubra pilaris. Early lesions of CTCL also tend to contain a polymorphic, nonspecific infiltrate without the presence of "Lutzner cells." This stage has been known to persist as "chronic nonspecific dermatitis" for at least two decades. Patients with persistent patchy dermatoses with clinical characteristics of early mycosis fungoides should have early and adequate skin biopsy. To make a diagnosis of mycosis fungoides, the biopsy should be at least 4 mm in diameter and, if there are several lesions present, at least two biopsies should be done on the thickest parts of separate lesions. If the biopsies are nondiagnostic and the dermatosis persists or worsens despite treatment, periodic biopsies have been recommended. A dermatologist well versed in this disease process is best able to select appropriate skin biopsy sites and the timing of repeat biopsies.

In a minority of patients, the earliest premycotic lesions present as either parapsoriasis en plaques large plaque type (termed "chronic superficial dermatitis" by Samman) or poikiloderma atrophicum vasculare (also termed "pre-reticulotic poikiloderma").¹⁰ Some consider these to be the same condition, stating that atrophy characteristic of poikiloderma may be delayed by two to three years. Those who classify these as separate conditions describe the first as erythematous patches with poorly defined borders (Figure 1), and the latter



Figure 3. The plaque stage superficially resembles psoriasis in that the lesions are well-defined, infiltrated, red, and annular. There usually are "skip areas" of normal skin within the plaque, however, and the micaceous scale of psoriasis is missing.



Figure 4. Advanced CTCL presents with rapidly expanding tumors which quickly ulcerate, hence, the metaphoric description, "mycosis fungoides"—like a fungating mushroom.

as patches with a reticulated (netlike) pigmentation and atrophy, telangiectasia, slight scaling, and an underlying erythema (Figure 2). These patches may show cigarette paper-like wrinkling and purpura; often are located over the breasts, buttocks, hips,

Table 1. Staging of cutaneous T cell lymphoma.

Classification	Description
T: Skin	
T ₀	Clinically and/or histopathologically suggestive lesions.
T ₁	Limited plaques, papules, or eczematous patches covering <10% of the skin surface.
T ₂	Generalized plaques, papules, or erythematous patches covering ≥10% of the skin surface.
T ₃	Tumors (≥1).
T ₄	Generalized erythroderma.
N: Lymph nodes	
N ₀	No clinically abnormal peripheral lymph nodes, pathology negative for CTCL.
N ₁	Clinically abnormal peripheral lymph nodes, pathology negative for CTCL.
N ₂	No clinically abnormal peripheral lymph nodes, pathology positive for CTCL.
N ₃	Clinically abnormal peripheral lymph nodes, pathology positive for CTCL.
B: Peripheral blood	
B ₀	Atypical circulating cells not present (<5%).
B ₁	Atypical circulating cells present (>5%); record total WBC and total lymphocyte counts and number of atypical cells/100 lymphocytes.
M: Visceral organs	
M ₀	No visceral organ involvement.
M ₁	Visceral involvement (must have pathology confirmation and organ involved should be specified).

abdomen, and major flexures, i.e. the axillae; in sun-protected areas; and clinically, though not histologically, resemble radiodermatitis. These patches often are unchanged over many years with some itching during winter, but gradually may become more thickened, or plaque-type, at which time skin histology may become more specific for mycosis fungoides.

The plaque stage arises from pre-existent patch stage disease or arises *de novo*. On the face, plaques can create leonine facies as seen in other infiltrative diseases, e.g. leukemia or lepromatous Hansen's disease. Elsewhere, these plaques can create a puckered "peau d'orange" appearance, or slightly scaly, erythematous plaques. These plaques may clear centrally and form bizarre arcuate patterns. Occasionally they spontaneously may regress, leaving residual hypo- or hyperpigmentation. However, they generally become thicker with time (Figure 3).

In the third stage, tumor or nodule formation occurs usually within plaques, but also on clinically normal skin. When tumors arise *de novo* (*d'emblee* type CTCL) with no preceding signs of clinical disease, this event may signify the emergence of a particularly aggressive clone of neoplastic cells or a sudden fall in host resistance. Tumors may occur anywhere on the body but are particularly common on

the face, scalp, and body folds (Figure 4). These usually are painless unless infected, though tender with pressure. My personal clinical observation has been that with increasing dermal infiltration there is epidermal thinning, and the skin surface becomes shiny and fragile, breaking down with slight trauma such as scratching. The tumors are prone to ulceration and secondary infection. Histological diagnosis usually is straightforward at this stage, but poorly differentiated infiltrates can lead to confusion with other malignancies such as histiocytic lymphoma or lymphosarcoma.

Generalized erythroderma may occur at any stage or as the presenting sign; scaling varies from minimal to severe. Islands of spared skin may be present. Associated signs include: palmoplantar fissuring, ectropion, poor temperature control, fever, and chills. Presence of tumors and/or erythroderma are associated with increased incidence of secondary infection.

With progressive disease, internal dissemination with lymph node and visceral involvement occurs.

HISTOLOGY

Light microscopic diagnosis of CTCL, especially in the patch stage, presents considerable difficulty: use of B-5 fixative for a few hours and preparation

of both routine paraffin and 1- μ Epon-embedded sections helps in making tissue lymphocytes stand out more clearly after staining.¹¹

In the patch phase, the dermal infiltrate consists of lymphocytes and histocytes; Lutzner cells may be absent, and even if present in small numbers, they are not specific for CTCL. Epidermotropism is highly suggestive of CTCL and consists of scattered mononuclear cells lying in the epidermis and separated from surrounding keratinocytes by a clear space or halo. When small groups of such cells are surrounded by a clear halo, they constitute a Pautrier microabscess.

In the plaque stage, the histologic picture is more specific: Lutzner cells are present in larger numbers, the dermal infiltrate tends to be bandlike in the upper dermis and patchy in the lower dermis, and epidermotropism and Pautrier's microabscesses usually are present.

In the tumor stage, large masses of cells are found in the dermis, compressing and thinning the epidermis, sometimes with epidermal ulceration. The infiltrate can extend below the dermis, and, at times, the mononuclear cells show blastic transformation. Epidermotropism no longer may be present, although it still may be found in coexisting patch and/or plaque stage lesions.

Newer diagnostic techniques which have been applied to help make earlier diagnoses include: immunophenotyping for T cell markers; electron microscopy with morphometric analyses of the nuclear contour index (NCI); DNA photocytometry which distinguishes benign from malignant tissue infiltrates; karyotyping which is used to diagnose blood or lymph node involvement by malignant cells; and gene rearrangement which can be done on skin biopsy material and detects abnormal cell clones.

EVALUATION AND STAGING

Clinical evaluation, once histologic diagnosis of a primary cutaneous lesion is made, should include: complete history and physical with mapping of skin lesions; complete blood count with a "Sézary-cell prep"; routine chemistries for liver, renal function, uric acid, calcium, LDH isoenzymes, and immunoglobulins; and lymph node biopsy (either an enlarged palpable node or an axillary, inguinal, or supraclavicular node when no clinical enlargement is present) for histologic and karyotyping analysis. Knobler and Edelson recommend liver and bone marrow biopsies if lymph nodes are positive for disease.¹ Further evaluation is suggested by results of the above testing.

Staging is based on a TNM (tumor, nodes, metastases) system, as recommended by the work-

Table 2. Lymph node class by biopsy.

LN 1:	Reactive node.
LN 2:	Dermatopathic node, small clusters of convoluted cells.
LN 3:	Dermatopathic node, large clusters of convoluted cells.
LN 4:	Lymph node effacement by malignant lymphoma.

shop on CTCL sponsored by the National Cancer Institute (Table 1).⁹

Clendenning has criticized the above classification since he believes that the level of significance for atypical circulating blood cells should be 10 percent, not 5 percent, as many normal individuals will show 5 to 10 percent activated lymphocytes when their blood smears are carefully examined.⁵

PROGNOSIS

The latest data collected from 152 patients referred to the National Cancer Institute between 1975 and January 1, 1987, show that patients with palpable adenopathy at initial diagnosis had a median survival of 40 months, whereas patients with plaque stage skin disease without adenopathy had a median survival of more than 12 years.¹²

Another significant finding was that incorporating the lymph node biopsy grading system (Table 2) into a staging system is useful for prognostic evaluations.¹²

Individuals with a LN 3 lymph node classification had median survival of 55 months as compared to 30 months for LN 4 classification. Median survival was over 90 months for patients with an LN 1 or LN 2 classification. Visceral disease was confirmed in 50 percent of patients with LN 4 nodes, compared with 16 percent of those with LN 3 nodes and only 2 percent of patients with LN 1 or LN 2 nodes. Mean survival in the presence of visceral disease was 25 months.¹²

ETIOLOGY

With the recent availability of monoclonal antibodies, cells from separate tumor lesions were found by Edelson to be monoclonal in origin. Edelson believes that CTCL from the beginning is a T cell malignancy with hematogenous spread occurring as soon as noncontinuous cutaneous lesions appear, a factor which he considers to be of utmost importance if cure, not palliation, is the eventual aim of treatment. However, Whang Peng has reported polyclonality among cells present in early multiple plaque lesions. Other investigators also have found

polyclonality of infiltrating cells. Such polyclonality supports the view that initially, in the majority of patients, an immune reactive process occurs due to chronic and perhaps multiple antigen stimulation and that only later does an aggressive malignant process occur.

Langerhans cells have been shown by special histological and immunological techniques to be present in CTCL infiltrates in increased numbers and often in apposition to T helper lymphocytes. Since Langerhans cells are believed to function as antigen presenters to T lymphocytes, this finding lends support to the theory of chronic and persistent antigenic challenge having a contributory role in the etiology of this disease.

THERAPY

To date, all available treatments, e.g. topical nitrogen mustard, topical nitrosourea (BCNU), electron beam and ionizing radiation, photochemotherapy with psoralens, and ultraviolet A light (PUVA) and systemic chemotherapy, have been palliative. Topical corticosteroids, ultraviolet B light, and various retinoids, i.e. 13-cis retinoic acid (Accutane®), etretinate (Tegison®), a retinoid Ro13-2698, have been used either alone or as adjunctive therapies.¹³

Extracorporeal photochemotherapy (photopheresis) is a new treatment which consists of oral methoxsalen administration followed by leukapheresis in which pooled leukocytes are irradiated with ultraviolet A (UVA) light extracorporeally. The UVA irradiation is accomplished by passing the separated pooled leukocytes as a 1 mm film through a disposable sterile six-chambered cassette. After this exposure, these irradiated leukocytes (which are esti-

mated to contain 30 to 50 percent of the patient's circulating lymphocytes) are reinfused to the patient. Edelson and coworkers have postulated that these UVA injured reinfused cells augment immune responsiveness to other malignant T cells in the patient's body. Adverse events reported during photopheresis include: postinfusion febrile spike and accentuation of erythema which resolve within a day, and hypotension during the leukapheresis stage, which has quickly responded to plasma infusion. There have been no reports of effects usually associated with chemotherapy such as gastrointestinal irritation, hair loss, and bone marrow suppression.¹⁴ While promising results have been seen, comparison with other forms of therapy regarding statistically significant increased survival benefit awaits results of further clinical trials.

SUMMARY

Cutaneous T cell lymphoma, previously known as mycosis fungoides, presents as either an aggressive disease (tumeur d'emblee type and the Sézary syndrome type) or a prolonged disease which evolves through patch, plaque, and tumor stages. Erythroderma is present either from the start or develops later in the disease process. Its incidence in the United States more than doubled from 1973 to 1984 (from 0.19 to 0.42 cases per 100,000 population). Staging classifications are being refined to reflect increasing knowledge of important prognostic indicators, e.g., absence or presence of lymph node involvement, pattern of lymph node involvement, and absence or presence of visceral disease. A number of newer treatment modalities is being investigated including the retinoids and ultraviolet A photopheresis. ■

REFERENCES

1. Knobler RM, Edelson RL: Cutaneous T cell lymphoma. *Med Clin North Am* 70:109-138, 1986.
2. Weinstock MA, Horm JW: Mycosis fungoides in the United States: Increasing incidence and descriptive epidemiology. *JAMA* 260:42-46, 1988.
3. Tuyp E, Burgoyne A, Aitchison T, et al.: A case-control study of possible causative factors in mycosis fungoides. *Arch Dermatol* 123:196-200, 1987.
4. Bunn PA Jr, Schechter GP, Jaffe E, et al.: Clinical course of retrovirus-associated adult T cell lymphoma in the United States. *N Engl J Med* 309:257-264, 1983.
5. Clendenning WE: Perspectives on cutaneous T cell lymphoma. *Clin Exp Dermatol* 11:109-126, 1986.
6. Lutzner MA, Jordan HW: The ultrastructure of an abnormal cell in Sézary's syndrome. *Blood* 31:719-726, 1968.
7. Edelson RL, Kirkpatrick CH, Shevach EM, et al.: Preferential cutaneous infiltration by neoplastic thymus-derived lymphocytes. *Ann Intern Med* 80:685-692, 1974.
8. Broder S, Edelson R, Lutzner M: The Sézary syndrome. A malignant proliferation of helper T cells. *J Clin Invest* 58:1297-1306, 1976.
9. Lamberg SI, Bunn PA: Proceedings of the workshop on cutaneous T cell lymphoma (mycosis fungoides and Sézary syndrome). *Cancer Treat Rep* 63:561-736, 1979.
10. Samman PD: Chronic superficial dermatitis and poikiloderma. *Bull Cancer* 64:177-186, 1977.
11. Myrie C, Zucker-Franklin D, Ramsey D: Light-microscopic analysis of sectioned Sézary cells. *Am J Pathol* 99:243-252, 1980.
12. Sausville EA, Eddy JL, Makuck RW, et al.: Histopathologic staging at initial diagnosis of mycosis fungoides and the Sézary syndrome: Definition of three distinctive prognostic groups. *Ann Intern Med* 109:372-382, 1988.
13. Tousignant J, Raymond GP, Light MJ: Treatment of cutaneous T cell lymphoma with a retinoid Ro 13-6298. *J Am Acad Dermatol* 16:167-171, 1987.
14. Edelson R, Berger C, Gasparro F, et al.: Treatment of cutaneous T cell lymphoma by extracorporeal photochemotherapy: Preliminary results. *N Engl J Med* 316:297-303, 1987.

Melanoma-Pigmented Lesion Center

DENNIS F. DEVEREUX, MD

Early diagnosis of cutaneous malignant melanoma is of critical importance as thin lesions equate with increased survival. Detection has been made easier by the development of a computer-programmed, high-resolution camera capable of detecting changes in surface area as well as low-level color changes, which are associated with radial (noninvasive) growth.

The incidence of cutaneous malignant melanoma is rising at a rate faster than almost any other cancer in man. Its rate is doubling every six to ten years. Due to the unavailability of effective chemotherapeutic agents, management of disseminated disease is palliative at best.

Innovative immunotherapeutic techniques championed by Rosenberg and colleagues at the National Cancer Institute have readdressed the problem of metastatic malignant melanoma. The combination of LAK (lymphokine activated killer cells) plus IL-2 (interleukin-2—a product of stimulated T-lymphokines) as an infusion has led to dramatic results in a small percentage of patients. However, as of 1989, the problem of treating metastatic melanoma has not been solved and much more investigative work will be necessary before such a

Dr. Devereux is associate professor and chief, section of surgical oncology, and codirector, Melanoma-Pigmented Lesion Center, UMDNJ-Robert Wood Johnson Medical School. Requests for reprints may be addressed to Dr. Devereux, Robert Wood Johnson University Hospital, One Robert Wood Johnson Place, CN-19, Department of Surgery, New Brunswick, NJ 08903.

treatment will be found. Indeed, many years of research will be invested before these treatments will then be available for the common physician or hospital use “off protocol.”

In the meantime, the most effective method at our disposal to deal with malignant melanoma is early detection. Early detection, i.e. prior to entry into the vertical growth phase and the development of metastatic potential, will allow us to detect and surgically treat thin lesions less than 0.76 mm thick; these lesions are associated with a very low systemic and nodal metastatic potential¹ and a 95 percent survival rate.

Once the vertical growth phase is entered, lesions become more deeply penetrating and their metastatic potential rises significantly. Our goal is prevention of this metastatic potential—when metastases occur, that usually signals the end to surgical treatment. Early surgical intervention in thin lesions can be curative and surgery continues to be the only proved successful treatment modality.

Early detection and surgical excision result in cures for many patients, therefore, these two aspects

Table. Summary of guidelines for surgery of primary cutaneous melanoma.

Primary Excision	
Tumor thickness	Margins
< 1.0 mm or "in situ"	1 cm
> 1.0 mm	3 cm and sq fat and underlying fascia
Lymph Node Dissection	
Thickness < 1.00 mm	Not recommended
Thickness 1.0-3.9 mm	Recommended
Thickness > 4.0 mm	Not recommended

of the management of cutaneous malignant melanoma will be addressed (Table).

Early detection of cutaneous malignant melanoma should be focused on those groups at highest risk: patients with previous melanoma history, patients with sporadic and, more importantly, familial dysplastic nevus syndrome, patients with certain congenital nevi, and patients at risk due to the known association of ultraviolet ray damage and host pigmentation (light complexion and a tendency to burn and freckle).^{2,4}

Patients at high risk are taught the ABCD's (asymmetry, border, color, and diameter evaluation criteria) and they, spouses, and family members are shown how to assist with these examinations.

The most helpful methods in evaluating patients with many lesions is photographic documentation. When more than 20 dysplastic lesions are found on a patient, documentation of size, color, and symmetry becomes very difficult and labor intensive. This makes the task of counting, assessing, and measuring tedious at best, and neglected at worst. I have reviewed many charts on patients with the dysplastic nevus syndrome and was surprised that many lesions were missed or were not noted on the chart—or were these new lesions? It is difficult to clinically distinguish a *de novo* lesion from a pre-existing one which was not charted or recorded.

VIDEO COMPUTER IMAGING SYSTEM

Using the 35 mm camera to document nevi too numerous to count has made the arduous task of "mole census" slightly easier; however, in the usual clinical circumstances, many of us do not have photographic quality lighting, a standardized measured distance from the subject, proper lens, or filters. The pictures of lesions lose much of their impact. Color, variegation, and borders usually are

lost due to a flash "hot spot" and we do not become aware of this until one to seven days later when the shots are returned. Therefore, the patient must be recalled or await the next visit for appropriate photographic documentation. Clearly, this is not the optimal method to follow patients with the many lesioned dysplastic nevus syndrome.

The Melanoma-Pigmented Lesion Center at UMDNJ-Robert Wood Johnson University Hospital has embarked on a novel, yet practical, approach to the treatment, management, and early detection of changes in patients with known melanoma and dysplastic nevi using a digitalized, high-resolution Sony camera-computer. This camera is capable of photographing lesions in room lighting, eliminating the "hot spot" noted on many 35 mm shots of flash photography. The digitalized components are capable of reducing or enlarging any lesion for closer inspection. When the image is blown-up, the variegated colors are seen more vividly. The blue, gray, red-brown, black, and white areas in a dysplastic mole or malignant melanoma become very apparent. The camera-computer is capable of detecting 32,000 different colors and shades (limited to 1,500 by the human eye). Image modification also is important to determine size or change in size of a lesion. The precise periphery can be measured and compared to any previous measurements made on that lesion in the past. In this way, we can detect a change in size, color, and shape before it becomes apparent to the examining physician. The digitalized camera preserves a permanent video film library unique to each patient. In this way, any change in the lesions can be detected or new lesions discovered by comparing videos.

We currently are programming the digitalized camera-computer to internally determine any change in size, border (periphery and total area), and color to help us to determine if and when a subtle change is noted. A comparison will be made and if there is a statistical difference (greater than 10 percent) compared to previous lesion characteristics, the computer will alert us to the change. In that way, early biopsy can be performed; this should allow us to detect any malignant transformation much earlier.

We do not advocate excision of all suspicious or dysplastic-appearing lesions, especially in those patients with 25 or more, as they soon become a "walking excision-blanket." The impracticality of 25 excisions in terms of health care dollars and time lost from work, makes use of the digital camera-computer an excellent cost-effective monitoring system. It can alert the physician as to which lesions should be biopsied instead of relying on clinical notes and physician memory. To date, we have a video library

consisting of over 50 patients and all suspicious lesions have been confirmed as having dysplastic or hyperplastic-melanocytic changes. We are conducting a prospective study on patients with suspicious or dysplastic lesions in an attempt to determine which is more satisfactory in detecting early melanoma changes in these nevi—the camera or the physician's eye. We predict the camera will be the victor in that contest.

It cannot be stated too strongly that biopsy of suspicious lesions is the most important diagnostic and definitive modality at our disposal for true, early detection. The biopsy should be full thickness into the subcutaneous fat and include an edge so lesion-skin interface may be evaluated.

MELANOMA MANAGEMENT

Surgery for cutaneous malignant melanoma is concerned with two issues: treatment of the primary site and treatment of the draining nodal basin. These concepts were first proposed by Dr. W. Sampson Handley who suggested excision of the primary lesions with a "wide margin" of skin and simultaneous removal of regional lymph nodes.⁵

Recent data suggest that the width of surgical resection margins may have no effect on survival, even for high-risk malignant melanoma.⁶ We use the following criteria for surgical excision at the Melanoma-Pigmented Lesion Center.

Surgical procedures are conducted at the Melanoma-Pigmented Lesion Center in an operating room environment. Minor surgical procedures as well as wide excisions with and without split thickness skin grafts are performed on an outpatient basis. We have not experienced a single case of a wound infection in over 200 surgical procedures.

We have adopted a protocol to perfuse deeply penetrating limb melanoma with chemotherapy at hyperthermic temperatures. This will be done on an inpatient basis in conjunction with the Vascular Surgery Service of Robert Wood Johnson University Hospital and UMDNJ/Robert Wood Johnson Medi-

cal School. Data presented by the West German University of Cologne has stimulated interest in the possibility of extending survival in patients with superficial as well as deep melanomas of the extremity.⁷

We suggest removal of regional lymph nodes for intermediate thickness melanomas based on several large uncontrolled series which have demonstrated an improved survival at five and ten years. Although these reports neither are prospective nor randomized, they do shed light on the microscopic metastatic potential of melanomas which have been microstaged accurately. It is overwhelmingly apparent that the thicker a lesion becomes, the greater propensity to produce not only locoregional but distant spread as well. The two studies which are used to dispell the efficacy of elective lymph node dissection (ELND) are flawed.^{8,9} Both the WHO group and the Mayo Clinic Study were predisposed to demonstrating a no survival benefit. Of the patients, 75 percent were women, which confers a favorable prognosis itself. Therefore, how could a study improve on an already preselected favorable bias? The latter study was biased since 62 percent of the participants were a Breslow level of favorable prognosis less than 1.5 mm thick which the author was quick to point out. Therefore, we are performing ELND until a multi-institutional prospective randomized study is completed, which currently is underway. The most interesting data forthcoming from this study for performing ELND may be in the unfavorable groups such as maleness, ulcerated lesions, and high lesional mitotic activity.

SUMMARY

Early detection, biopsy confirmation, and adequate surgical treatment of the primary lesion as well as ELND, if the lesion measures 1.5-3.99 mm in thickness, affords the best chance in preventing morbidity and mortality from cutaneous malignant melanoma, as systemic treatments to date have not been efficacious. ■

REFERENCES

1. Balch C: Surgical management of regional lymph nodes in cutaneous melanoma. *J Am Acad Dermatol* 3: 511-524, 1980.
2. Gallagher RP, et al.: Risk factors for cutaneous malignant melanoma: The Western Canada melanoma study. *Recent Results Cancer Res* 102: 38-55, 1986.
3. Dubin N, et al.: Epidemiology of malignant melanoma: Pigmentary traits, ultraviolet radiation, and the identification of high-risk populations. *Recent Results Cancer Res* 102: 58-75, 1986.
4. Elwood JM, et al.: Pigmentation and skin reaction to sun as risk factors for cutaneous melanoma. Western Canada Melanoma Study. *Br Med J* 288: 99-102, 1984.
5. Handley WS: The pathology of melanotic growths in relation to their operative treatment. *Lancet* 907-1003, 1907.
6. Day CL, et al.: Narrower margins for clinical stage I malignant melanoma. *N Engl J Med* 302: 479-482, 1982.
7. Ghussen F, et al.: The role of regional hyperthermic cytostatic perfusion in the treatment of extremity melanoma. *Cancer* 61: 654-659, 1988.
8. Sim FH: Lymphadenectomy in the management of stage I malignant melanoma: A prospective randomized study. *Mayo Clinic Proc* 61: 697-705, 1986.
9. Veronesi A, et al.: WHO study—prospective, randomized, and multi-institutional. *N Engl J Med* 297: 627-630, 1977.

Continuing Medical Education Seminars

J • U • N • E

Stone Busters

Non-Surgical Management of Biliary Stones

Don't miss this valuable opportunity to examine the role of dissolving agents and shock wave therapy in the management of biliary stones. The day-long conference will feature world-renowned experts on the subject.

Saturday, June 3, 1989

8 A.M.-4:15 P.M.

Claridge Hotel & Casino
Atlantic City, New Jersey

*Sponsored by Atlantic City Medical Center
Division of Gastroenterology
Department of Medicine*

New Concepts in the Diagnosis and Treatment of Cancer

This conference is designed to inform the audience of the most sophisticated concepts in the diagnosis and treatment of cancer in the 1990's. It will provide useful information for internists, oncologists, surgeons, family practitioners, OB/GYN's and other specialists whose practices involve the treatment of cancer. The day-long conference will feature world-renowned cancer experts.

Saturday, June 17, 1989

8 A.M.-4 P.M.

TropWorld Casino & Entertainment Resort
Atlantic City, New Jersey

*Sponsored by the Atlantic City Medical Center
Ruth Newman Shapiro Regional Cancer Center*

Atlantic City Medical Center designates these continuing medical education activities for 7 credit hours each in category 1 of the physicians recognition award of the American Medical Association.

For a brochure including complete conference information or to make reservations call

Mary Lou Faulk at 609-441-2110.



Michigan Avenue at Pacific
Atlantic City, New Jersey 08401

CONTINUING EDUCATION

ALLERGY

June

- 2 **Allergy Journal Club**
8 A.M.—New Jersey Medical School, Newark
- 23 *(UMDNJ)*

CARDIOLOGY

June

- 14 **Thrombolytic Therapy**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic
(AMNJ)
- 15 **The Dilemmas of Silent Myocardial Ischemia**
12 Noon-1:30 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center)
- 20 **Sudden Cardiac Death**
9-10 A.M.—Holy Name Hospital, Teaneck
(AMNJ)
- 21 **Cardiac Rehabilitation**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

INFECTIOUS DISEASES

June

- 1 **Counseling and Testing for HIV Infection**
11:45 A.M.-1 P.M.—John F. Kennedy Memorial Center, Edison
(AMNJ and NJDOH)
- 2 **Counseling and Testing for HIV Infection**
12 Noon-1 P.M.—South Jersey Hospital System/Bridgeton Division
(AMNJ and NJDOH)
- 7 **Clinical Management of HIV Infection**
11 A.M.-12 Noon—Zurbrugg Hospital, Riverside
(AMNJ and NJDOH)
- 8 **Clinical Management of HIV Infection**
2:30-3:30 P.M.—Ancora Psychiatric Hospital,

Hammonton
(AMNJ and NJDOH)

9 Clinical Management of HIV Infection

12 Noon-1 P.M.—South Jersey Hospital System/Bridgeton Division
(AMNJ and NJDOH)

23 Counseling and Testing for HIV Infection

12 Noon-1 P.M.—Freehold Area Hospital, Freehold
(AMNJ and NJDOH)

28 Counseling and Testing for HIV Infection

12 Noon-1 P.M.—St. James Hospital, Newark
(AMNJ and NJDOH)

July

11 Counseling and Testing for HIV Infection

9-10 A.M.—Holy Name Hospital, Teaneck
(AMNJ and NJDOH)

13 Counseling and Testing for HIV Infection

2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ and NJDOH)

MEDICINE

June

- 1 **What the Primary Physician Must Know and Do To Save Diabetic Legs**
2:30-3:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ and NJDOH)
- 6 **Annual Symposium**
5:15-8:30 P.M.—UMDNJ, New Brunswick
(NJ Health Sciences Group/ Basic Sciences Section—AMNJ)
- 7 **Polypharmacy and Psychopharmacology**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic
(AMNJ)
- 7 **Annual Joint Meeting**
3-9 P.M.—The Manor,

West Orange
(NJ Gastroenterological Society/ NJ Society for Gastrointestinal Endoscopy and AMNJ)

7 Annual Pacemaker Meeting

8:30 A.M.-3:30 P.M.—Sheraton at Woodbridge Place, Iselin
(Newark Beth Israel Medical Center and AMNJ)

9-10 Physician Reimbursement in an Era of Cost Containment

9 A.M.—Holiday Inn, Newark Airport, Newark
(Seton Hall University and AMNJ)

12 Hepatitis

12 Noon-1 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ)

13 Osteoporosis

9-10 A.M.—Holy Name Hospital, Teaneck
(Holy Name Hospital)

14 CDS Prescribing Practices: Legal/Illegal

10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

14 Occupational Medicine

1-2 P.M.—Woodbridge Developmental Center, Woodbridge
(AMNJ)

16 Occupational Asthma in New Jersey

8:30-9:30 A.M.—Chilton Memorial Hospital, Pompton Plains
(AMNJ and NJDOH)

21 Abortion and Reproductive Wastage

8-9 A.M.—Warren Hospital, Phillipsburg
(AMNJ)

26 Asbestos-Associated Diseases

9-10 A.M.—Warren Hospital, Warren
(AMNJ)

July

- 5 **What the Primary Physician Must Know and Do To Save Diabetic Legs**

11 A.M.-12 Noon—Morristown Memorial Hospital, Morristown (AMNJ and NJDOH)

NEPHROLOGY

June

- 7 **Annual Scientific Session and Dinner**
6:30-9 P.M.—UMDNJ, MEB-108, New Brunswick
(Nephrology Society of NJ and AMNJ)

ONCOLOGY

June

- 1 **Cancer Research Colloquium**
8 3-4 P.M.—New Jersey Medical School, G-506B, Newark
15 (UMDNJ)
22
29
1- **Oncology Society of New Jersey, Annual Meeting**
4 Marriott's Castle Harbour, Bermuda
(Oncology Society of New Jersey and AMNJ)
23 **Head and Neck Oncology**
7:30-8:30 A.M.—Atlantic City Medical Center, Atlantic City (AMNJ)

PSYCHIATRY

June

- 1 **Brain Grafting: Can We Be Rejuvenated?**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead

(Carrier Foundation)

- 2 **Psychiatric Lecture Series**
9 1:30-3:45 P.M.—Trenton Psychiatric Hospital, Trenton
16 (Trenton Psychiatric Hospital and AMNJ)
7 **Case Seminars To Improve Psychotherapeutic Technique**
21 8-10 P.M.—2 West Northfield Road, Livingston
(Advanced Psychiatric Study Group and AMNJ)
8 **Recent Research Advances in Teenage Suicide**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)
14 **Psychoneuroimmunology**
All day—Carrier Foundation, Belle Mead
(Carrier Foundation)
15 **The Adolescent Sexual Offender**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)
29 **Doctor-Patient Relationship and Noncompliance**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

July

- 6 **Seasonal Depression**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)
13 **The Return of the Forensic Patient to Society**
12 Noon-1 P.M.—Carrier

Foundation, Belle Mead (Carrier Foundation)

- 20 **AIDS: Managing the Psychosocial Impact**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

SURGERY AND ITS SPECIALTIES

June

- 7 **In and Out Surgery**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(Christ Hospital)
12 **Surgical Management of Benign and Malignant Disease of the Breast**
12 Noon-1 P.M.—The Hospital Center at Orange, Orange
(AMNJ)
23 **Surgical Treatment of Morbid Obesity**
7:30-8:30 A.M.—Atlantic City Medical Center, Atlantic City
(AMNJ)

UROLOGY

July

- 21 **Urology-TUR**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic
(AMNJ)
22 **Clinical Cases Presentation**
6:30-7 P.M.—Robert Wood Johnson Medical School, New Brunswick
(UMDNJ)

NEW JERSEY MEDICINE

presents a 4-color
Special Issue:

Skin Cancer in New Jersey

\$6.50

May 1989

Send check to: NEW JERSEY MEDICINE
Two Princess Road
Lawrenceville, NJ 08648

NOTEBOOK

TRUSTEES' REPORT

A regular meeting of the Board of Trustees was held on Sunday, February 19, 1989, at the Executive Offices. A detailed report is on file with the secretary of your county society. A summary of significant actions follows:

Report of Executive Director . . .

(1) **Membership . . .** Noted active membership count for MSNJ and AMA; also, study of dues-paid memberships for a five-year period showed an increase of 40 members.

(2) State Board of Medical Examiners . . .

(a) **In re Sinha . . .** Approved MSNJ's amicus entry into this case which concerns the suspension of the license of an anesthesiologist involved in an event at an abortion clinic.

(b) Postsurgical Care of Ophthalmological Patients . . .

Awaiting a response from SBME concerning the position that ophthalmologists could not refer patients to optometrists for postsurgical care.

(c) Amicus Request Re Physical Therapy Suit . . .

Asked that SBME provides a statement to the effect that the regulation of the State Board of Physical Therapy is inappropriate.

(d) **Bill A-3468 . . .** Has taken a position of active opposition to this bill which proposes to add a chiropractor to the Medical Advisory Council of the State Athletic Control Board.

(3) Medical Malpractice Surcharge . . .

Noted that Mr. Maressa expressed optimism that

a satisfactory conclusion may be reached in this matter without litigation.

(4) **NJHA versus Ombudsman for the Institutionalized Elderly . . .** Noted that a motion to intervene in the suit promulgated by NJHA has been filed, and a brief on behalf of MSNJ, opposing the ombudsman's letter, is being prepared.

(5) HCFA Substandard Care Regulations . . .

Noted that MSNJ will submit comments opposing the proposal to revise federal regulations governing PRO review which deal with denial of payment for substandard quality care and review of beneficiary complaints.

(6) Medicare Secondary Payor Determinations . . .

Noted that the AMA has taken a position with HCFA that Medicare should pay all assigned claims directly to the physician whether it is primary or secondary.

(7) Medicare (B) ICD-9 Codes . . .

Was introduced to Eileen M. Moynihan, MD, the newly appointed medical director of Pennsylvania Blue Shield; noted that Pennsylvania Blue Shield will not be ready to use the new coding system on April 1, 1989.

(8) Medical Discipline and Licensing—S-2936 . . .

Was advised by Mr. Maressa that MSNJ does not intend to request a large number of physicians to appear at the hearing for this bill since it is to be a technical presentation.

(9) S-216—Chiropractic Board . . .

Noted that a special committee will be formed to review MSNJ's position on this bill which

sets up a separate licensing board for chiropractic.

(10) Structured Payments—S-1845 . . .

Noted that this bill has been referred back to the Senate Judiciary Committee.

UMDNJ Report . . .

Noted the following items presented by Paul F. Larson, MD, senior vice-president of academic affairs: recruitment of students for allied health/nursing programs; continuing progress in establishing a department of family medicine; and the need to employ 400 additional faculty members for UMDNJ to realize its "top 25" goal.

New Jersey Hospital Association . . .

Noted the following items presented by Louis Scibetta: a suit filed by NJHA against the Hospital Rate-Setting Commission; payments into the Uncompensated Care Trust Fund are capped at 13 percent of total revenue and individual hospitals can appeal; HCFA's program of accelerated payments to address hospital cash flow problem is merely a stopgap measure; and a complaint filed by NJHA against the New Jersey Ombudsman for the Institutionalized Elderly alleging he was not in compliance with the administrative procedure act when he issued guidelines governing the withdrawal of medical support and treatment from such patients.

County Society Forum . . .

Requested input from the Council on Medical Services and the Hospital Medical Staff Section before taking a position on the resolution

concerning surgical assistants.

MSNJ Auxiliary . . . Noted the Auxiliary annual trip to Washington, DC, to meet with legislators.

Council on Medical Services . . . Voted to accept the following recommendation:

That Blue Cross-Blue Shield of New Jersey be requested to adopt the following policy: participating physicians in New Jersey Blue Shield should be paid directly by Blue Shield unless they have specifically advised Blue Shield to pay the patient directly.

Committee on Emergency Medical Care . . . Voted unanimously to adopt Resolution #15:

Resolved, that MSNJ support the development of a coordinated emergency medical services system in New Jersey to assist in education, administration, and development of emergency medical services; and be it further Resolved, that MSNJ support the recommendations of the Governor's Council on Emergency Services.

Ad Hoc Committee on Women in Medicine . . . Approved the following recommendation as amended:

That the Board of Trustees encourage county medical societies, in addition to their present recruitment program, to assign one or more women physicians to be responsible to contact women physicians who are newly licensed, or newly appointed to the hospital staff, and encourage their membership in organized medicine (and that their names be forwarded to MSNJ).

Also, noted the following recommendation was referred to the Committee on Long-Range Planning and Development for study and report back to Board:

That the Board of Trustees investigate a reduced dues category for all physicians who work 20 hours or less per week.

Task Force on the Shortage of Nurses and Technical Personnel . . . Unanimously approved the following recommendation:

That the New Jersey State Nurses Association be included as a co-sponsor of the proposed symposium regarding professional relationships, with MSNJ and NJHA.

Conference on Focus Prescribe Remedial Education for Enhanced Clinical Competence . . .

Voted to postpone consideration of Dr. Formica's request for a conference to extend a helping hand to physicians whose performance has become substandard, for whatever reason.

JEMPAC . . . Noted the following: Dr. Edward A. Schauer was appointed JEMPAC secretary; financial support will be provided to gubernatorial candidates and support for Assembly candidates will be determined later; and approved a MedAC fundraising letter.

Unfinished Business . . .

(1) Nominations for Emeritus Membership . . . Noted that the Committee on Revision of Constitution and Bylaws will review the requirements for emeritus membership.

(2) SBME Percentage Service Agreements . . . Noted that Mr. Maressa requested SBME to provide MSNJ with a statement concerning "safe harbor" criteria.

New Business . . .

Medicare Reimbursement for Psychologists . . . Approved the request to direct a communication to the AMA and New Jersey's congressional representatives concerning non-MD's being reimbursed through Medicare Part B. □

TRUSTEES' REPORT

A regular meeting of the Board of Trustees was held on Sunday, March 19, 1989, at the Executive Offices. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Category: (Please check one)

☐ Member, MSNJ ☐ Subscriber, NJ Medicine

☐ Other _____

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____

Report of the President . . .

(1) AMA Delegation . . . Noted that Dr. Formica requested all members of the AMA delegation to attend Board meetings; discussion and action on the AMA delegation handbook was postponed.

Report of Executive Director . . .

(1) MSNJ Financial Statements . . . Reviewed and approved MSNJ's financial statements for the period ending January 31, 1989.

(2) MSNJ Paid Memberships . . . Noted that there were 6,395 paid memberships as of March 17, 1989.

(3) MSNJ Membership Directory/Special Assessment . . . Noted that members who did not pay the \$100 special assessment mandated by the 1987 House of Delegates would not be listed in the 1989 *Membership Directory*. (Note: 92 percent of dues-paying members paid the special assessment.)

(4) Medical Malpractice Surcharge . . . Received a copy of the response of special counsel, Judge Herbert Stern, to hearing officer Bakke's report regarding the proposed medical malpractice surcharge ruling.

(5) Medicare/ICD-9 Codes . . . Noted that Mr. Maressa and Mr. Lucci met with representatives of Pennsylvania Blue Shield and were advised that a number of basic issues were discussed which have been or are about to be resolved; also, problems with specific physician files will be handled as individual items and physicians were urged to document denials and to send supporting data to MSNJ.

(6) Medical Discipline and Licensing—S-2936 . . . Noted that the committee hearing is scheduled for April 13, and is to be a technical markup session at which time Judge Stern will present further amendments.

(7) MSNJ versus Ombudsman

. . . Agreed to intervene in the lawsuit instituted by the New Jersey Hospital Association against the ombudsman for the institutionalized elderly, concerning the position on the Mandatory Report of Adult Abuse Law as indicated in a letter to nursing home administrators.

(8) PRO Substandard Care Notification . . . Received a copy of MSNJ's letter to the Health Care Financing Administration on the proposed rule on quality of care denials and review of beneficiary complaints under the Medicare and Medicaid programs.

(9) MSNJ Membership Blue Cross/Blue Shield Programs . . . Voted to discuss, in executive session, a matter relating to the major medical portion of the membership's health insurance program.

UMDNJ Report . . . Noted the following items from Dr. Bergen's report: the first liver transplant in New Jersey was performed at University Hospital, Newark; UMDNJ was honored for its business contracts to minority firms during 1988; a new outpatient center opened in Camden for the diagnosis and treatment of young adults suffering from sickle cell anemia and other red blood cell disorders; University Hospital and its major affiliated hospitals joined forces to effect a change in the new re-basing system for DRGs, in an effort to improve the reimbursement system for graduate medical education; Joint Commission on Accreditation of Health Care Organizations was the subject of an article in the *Wall Street Journal*, alleging a coverup on hospital accreditation; and, urged all state medical societies to support the candidacy of Dr. John Chapman for the AMA Council on Medical Education and Dr. Robert Walden for the AMA Council on Scientific Affairs, and noted Dr. Tupper being running for AMA president-elect.

County Society Forum . . . Will refer to the Committee on Utilization Review Systems concerns by members from the Fourth and Fifth Judicial Districts, concerning physician signatures on discharge attestations.

Committee on Long-Range Planning and Development . . . Approved the following recommendation:

That each county medical society be requested to develop a membership recruitment program, with the understanding that the Medical Society of New Jersey is ready to assist them in their endeavors whenever necessary.

Also, approved the following recommendation as amended:

That a one-day orientation and leadership conference be held each June for county medical society and specialty society officers; MSNJ council and committee members.

And, referred the following recommendation back to the Committee:

That members of the Board of Trustees, members of the AMA Delegation, and chairmen of councils and committees be required to attend the conference at least once during their tenure.

Committee on Revision of Constitution and Bylaws . . . Noted that the following topics and their proposed bylaw amendments were approved by the Committee for presentation to the House of Delegates: discontinuance of the Advisory Committee to the Auxiliary; special assessments; changes in the status of emeritus membership category; and repeal of age-related dues exemption.

Task Force on the Shortage of Nurses and Technical Personnel . . . Requested a physician member of the Task Force to represent MSNJ at the symposium sponsored by NJHA on April 28, 1989.

Committee on Appointments . . .
Reviewed, modified, and accepted from Dr. Hirsch, chairman of the Committee, a document setting forth guidelines for appointments to the Society's councils and the committees; and approved the following recommendation:

That the Special Committee on Drug and Alcohol Abuse be discharged.

Ad Hoc Committee on Graduates of Non-U.S. Medical Schools . . .
Approved the following recommendation:

That the Ad Hoc Committee on Graduates of Non-U.S. Medical Schools be made a permanent committee of the Society. ☐

ICD-9-CM

The AMA has published an informational brochure for physicians and their office staff which presents a brief overview of the legislation, a summary of HCFA's coding guidelines, and a discussion of how the new coding require-

ments will affect billing procedures in physicians' offices. This brochure is entitled, *New Medicare ICD-9-CM Coding Requirements*, and is available to members free of charge upon written request addressed to Joseph C. Lucci, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

Volumes 1 and 2 of the *ICD-9-CM, Third Edition*, are available from the Government Printing Office and the order form is reprinted; you receive: • the cloth-bound official U.S. Government third edition; • assured receipt of all addenda to be issued through 1991 (addenda will not be sold separately); and • shipment by priority mail.

UMDNJ NOTES

UMDNJ has been expanding specialized services for the elderly throughout the state. In northern New Jersey, a specialized dental clinic for senior citizens is providing comprehensive care and in-

creased services at three satellite centers operated by the Newark-based UMDNJ-New Jersey Dental School. The clinic also serves as a training ground for the school's postgraduate students. Oral health-care services are being added to existing outreach programs in southern New Jersey by the Center for Aging at the UMDNJ-School of Osteopathic Medicine in Stratford. The expanding program in southern New Jersey is being made possible by a \$450,000 grant from the U.S. Department of Health and Human Services. New services include dental services as part of the geriatric mobile van, and a five-chair dental clinic at the School of Osteopathic Medicine in Stratford, offering the elderly medical and dental care. Long-term plans include establishing satellite geriatric centers in Camden and Atlantic City.

In the past 11 years, the dental school has created dozens of programs for the elderly, including

ORDER FORM

☐ **YES**

Please enter my order for _____ copies of **ICD-9-CM, Third Edition, Vols. 1 & 2** at \$43 domestic (\$53.75 foreign). I understand that it will be shipped by priority mail and that I will automatically receive all addenda issued through 1991 at no additional cost.

Name _____

Please indicate method of payment:

☐ Check payable to Superintendent of Documents.

☐ Charge my VISA or MasterCard Account Number.

Street Address (Sorry, No P.O. Boxes) _____

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

(Expiration Date) _____

City, State & ZIP Code _____

() _____

Phone _____

(Signature) _____

Thank you for your order!

Charge Your Order.

It's easy!



Purchase Order Number _____
(# purchase order included.)

Note:

Do not use this special order form or address after October 31, 1991.

Send this order to:

ICD-9-CM, Third Edition, Vols. 1 & 2

P.O. Box 360121

Pittsburgh, PA 15250-6121

satellite centers in Essex and Hudson counties, a geriatric division to train dentists, a diagnostic and treatment program for Alzheimer's disease patients, and sponsorship of postgraduate training.

Six years ago, the School of Osteopathic Medicine created its Center for Aging. The Center runs an Alzheimer's disease evaluation program, geriatric assessment service, geriatric ambulatory health care service, home-care services, and a mobile home-care van.

In central New Jersey, a "respite" program for families of individuals with Alzheimer's disease and related ailments has opened in Middlesex County. The program, the first of its kind in the county, is offered at our UMDNJ-Community Mental Health Center in Piscataway and provides free time for those who care for persons with Alzheimer's and other dementing illnesses. The program is part of UMDNJ's Comprehensive Services on Aging unit.

Improved diagnosis and treatment of heart, lung, brain, and musculoskeletal diseases are the goals of a \$200,000 research grant awarded to UMDNJ by Ciba-Geigy. Hypertension, heart disease, arthritis, sleep disorders, and cancer are among 17 projects slated for study under the two-year grant awarded to the department of radiology at UMDNJ-Robert Wood Johnson Medical School. The studies will be based at the Laurie Imaging Center, New Brunswick, which houses two magnetic resonance imaging (MRI) units. The facility provides advanced diagnostic services to area hospitals and physicians. ■ Stanley S. Bergen, Jr, MD

PLACEMENT FILE

The following physicians have written to the Executive Offices of MSNJ seeking information on opportunities for practice in New Jersey. The information listed below

has been supplied by the physicians. If you are interested in any further information concerning these physicians, please make inquiries directly to them.

FAMILY PRACTICE

- Tariq H. Butt, MD, 605 West Madison Ave., #2606, TWR #3, Chicago, IL 60606. Dow (Pakistan) 1980. Board eligible. Group or partnership. Available July 1989.
- Eileen Hill, MD, 155 Briarwood Rd., Mt. Laurel, NJ 08054. Pennsylvania 1980. Board certified. Part time. Available.
- Sergiusz I. Kaftal, MD, 4114 9th Ave., Brooklyn, NY 11232. Lodz (Poland) 1981. Solo, partnership, single specialty group. Available.
- Steven Luke, MD, 111 Hicks St., 9P, Brooklyn, NY 11201. SUNY-Upstate 1982. Also, pediatrics. Board certified. Board eligible (PED). Group. Available.

GASTROENTEROLOGY

- Robert I. Leventhal, MD, 1000 J Scaife Hall, Division of Gastroenterology, University of Pittsburgh, Pittsburgh, PA 15217. St. Georges (Grenada) 1984. Board eligible. Consultative, group, partnership, solo. Available July 1989.

HEMATOLOGY

- Vijaykumar Gandhi, MD, I 2126 Chapin Apts., SUNY, Stony Brook, NY 11794. Baroda (India) 1981. Also, internal medicine. Board eligible. Board certified (IM). Group, partnership, solo. Available July 1989.

INTERNAL MEDICINE

- Nancy Hsueh Beggs, MD, 242 East Second St., Atco, NJ 08004. Temple 1986. Board eligible. Group or multispecialty practice. Available July 1989.
- Ezra Bendit, MD, 22 Mt. Rascal Rd., Hackettstown, NJ. UMDNJ 1984. Board certified. Group or partnership. Available.
- Bhuvana Chinnappan, MD, 139 Wm. Feather Dr., Voorhees, NJ 08043. Board eligible. Group, partnership, solo. Available.
- Prakash J. Doshi, MD, 5676 Broadview Rd., #507, Parma, OH 44136. Bombay (India) 1984. Board

eligible. Solo, partnership, group.

- Albert S. Ford, MD, 4 Linden Lane, Scotch Plains, NJ 07076. Meharry (India) 1982. Board eligible. Solo. Available.
- Vijaykumar Gandhi, MD, I 2126 Chapin Apts., SUNY, Stony Brook, NY 11794. Baroda (India) 1981. Also, hematology/oncology. Board certified. Board eligible (HEMATOL). Group, partnership, solo. Available July 1989.
- Lalitha B. Iyer, MD, 35 Winthrop Rd., Edison, NJ 08817. Madras (India) 1980. Board eligible. Group, partnership, emergency room. Available.
- Donald Mitrane, MD, 129 Broadway, Apt. C., Huntington Station, NY 11746. Columbia 1989. Board eligible. Group or partnership. Available July 1989.

OPHTHALMOLOGY

- Lawrence Scott Halperin, MD, 5571-D Waterman, St. Louis, MO 63112. Pennsylvania 1985. Board eligible. Group practice. Available July 1991.

PEDIATRICS

- Steven Luke, MD, 111 Hicks St., 9P, Brooklyn, NY 11201. SUNY-Upstate 1982. Also, family practice. Board eligible. Board certified (FAM MED). Group. Available.
- Niranjan S. Patel, MD, 2003 Valley View Dr., Pineville, LA 71360. B.J. Medical College (India) 1982. Board eligible. Also, emergency medicine. Group, hospital-based, partnership. Available July 1989.

RADIOLOGY

- Robert W. Cifers, MD, 6913 Bonnie Ridge Dr., Apt. T1, Baltimore, MD 21209. Ohio State 1983. Board eligible. Also, nuclear medicine. Group, partnership, solo. Available.

SURGERY

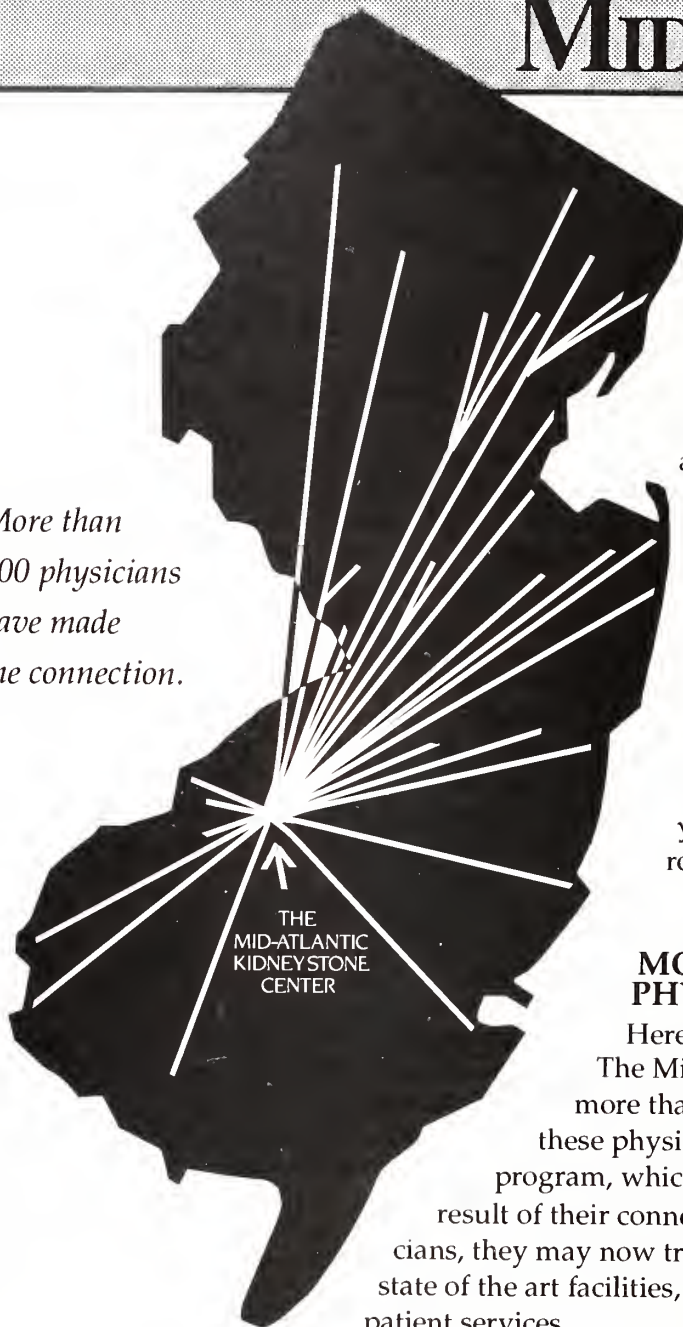
- Robert A. Aldoroty, PhD, MD, 1270 Fifth Ave., New York, NY 10029-3417. Columbia 1984. Board eligible. Group or partnership. Available July 1989.

UROLOGY

- David S. Altman, MD, 402 Laura Dr., Danville, PA 17821. Jefferson 1985. Board eligible. Group, partnership, multispecialty. Available July 1990.

EXPERIENCE & MID-ATLANTIC

*More than
100 physicians
have made
the connection.*



For physicians throughout New Jersey and from as far away as eastern Pennsylvania, metropolitan New York and Delaware, *Mid-Atlantic* is synonymous with *experience*.

Consider the following: we recently treated our 4,800th patient, a milestone for lithotripter units in the eastern region. Reading between the numbers, we see an unparalleled depth of experience that enables us to deliver the clinical excellence and full-service support you demand.

As the result of more than three years' experience, we have developed a unique sensitivity to your patients, your concerns and the role that we play as a service to both.

MORE THAN 100 STAFF PHYSICIANS AND GROWING

Here's another fact we're proud of: The Mid-Atlantic Kidney Stone Center has more than 100 physicians on staff. Many of these physicians learned lithotripsy through our program, which is now AUA and ALS certified. As a result of their connection to Mid-Atlantic as staff physicians, they may now treat their patients here, enjoying our state of the art facilities, full support staff and comprehensive patient services.

MAKE THE CONNECTION TODAY

Mid-Atlantic's experience is yours for the asking. To find out more about Mid-Atlantic's services and our physician training program, call us at 1-800-53-LITHO or (609) 983-7337.



**THE MID-ATLANTIC
KIDNEY STONE CENTER**

A LITHOTRIPTER SERVICE
One Brick Road, Suite 103
Marlton, NJ 08053

Managed by
MEDIQ Healthcare Resources, Inc.

IN MEMORIAM

Leonard R. Barris. Word has been received of the death of Leonard Ralph Barris, MD, in January 1989. Born in 1921 in Brooklyn, New York, Dr. Barris was awarded a medical degree from New York University-Downstate Medical Center in 1948. For the next ten years, Dr. Barris served as a junior and senior high school teacher in New York City. In 1966, Dr. Barris was affiliated with the Radiology Department at Montefiore Medical Center, New York, after receiving his license to practice medicine in 1965. During his career as a radiologist, Dr. Barris was associated with Einstein Medical University, New York, and was a member of our Essex County component and of the American Medical Association.

Robert E. Bennett. Retired psychiatrist Robert Eugene Bennett, MD, died on January 5, 1989, at the age of 76. Born in Kingston, Pennsylvania, Dr. Bennett received his medical degree at the University of Pennsylvania School of Medicine, Philadelphia, in 1938. A diplomate in psychiatry and neurology, Dr. Bennett was a staff member of Trenton Psychiatric Hospital from 1952 to 1958; a psychiatrist for the Skillman Center from 1958 to 1968; and the director of the outpatient clinic for the Carrier Clinic from 1968 to 1977. An instructor in psychiatry for the University of Pennsylvania School of Medicine, Dr. Bennett was a member of the American Psychiatric Association, of the Group for the Advancement of Psychiatry, of

our Somerset County component, and of the American Medical Association. During World War II, he served as a United States Air Force flight surgeon.

Sidney Brooks. After 20 years of retirement in Florida, former Paterson orthopedic surgeon Sidney Brooks, MD, died on December 20, 1988, at the age of 90. Born in New York City, Dr. Brooks received his medical degree from Cornell University Medical College, New York, in 1925. In addition to having a private practice, he was affiliated with St. Joseph's Hospital and Medical Center, Paterson. Dr. Brooks was a fellow of the American College of Radiology, and was a member of our Passaic County component, and of the AMA. He received the Medical Society of New Jersey's Golden Merit Award in 1975, in recognition of his 50 years as a physician.

Benjamin B. Burrill, Jr. Montclair dermatologist Benjamin Brooks Burrill, Jr, MD, died on December 28, 1988. A 1910 Irvington native, Dr. Burrill was graduated from Duke University School of Medicine, Durham, North Carolina, in 1936. He became affiliated with The Mountainside Hospital, Montclair, and the Veterans Administration Medical Center, East Orange, where he was head of dermatology. A diplomate in dermatology and an associate fellow of the American College of Allergists, Dr. Burrill was a member of our Essex County component, of the AMA, of the Society of Trop-

ical Dermatology, and of the New Jersey Dermatology Society. In 1986, he received MSNJ's Golden Merit Award for 50 years of medical practice.

Anthony G. Campo. Westville family physician Anthony Guy Campo, MD, died on December 27, 1988. Born in 1909 in Philadelphia, Pennsylvania, Dr. Campo received his medical degree at Hahnemann Medical College and Hospital, Philadelphia, in 1935. He became affiliated with Our Lady of Lourdes Medical Center and West Jersey Hospital, both in Camden; and Underwood-Memorial Hospital, Woodbury. A fellow of the American Academy of Family Practitioners, Dr. Campo was a member of our Gloucester County component, serving as its president in 1951. He also was a member of the AMA, of the New Jersey State Homeopathic Society, and of the Philadelphia Medical Club. Active in the community, Dr. Campo was fire surgeon for the Union Fire Company, Westville, and was school physician for Deptford Township. For 50 years as a physician, Dr. Campo received the Golden Merit Award.

Carlos M. Cane. Following a year of retirement in Florida, former Hoboken urologist Carlos Mario Cane, MD, died on January 3, 1989, at the age of 68. A native of Argentina, Dr. Cane was awarded his medical degree from the School of Medicine, University of Buenos Aires, in 1948. In addition to maintaining a family

practice, Dr. Cane served on the staff of St. Mary Hospital, Hoboken, as director of ambulatory care and as a teacher of emergency service. A fellow of the American Urological Association, Dr. Cane was a member of our Union County component, of the AMA, of the American College of Emergency Physicians, of the AAFP, and of the Society for Teachers of Family Practice.

John E. Caton. Psychiatrist John Edward Caton, MD, died on December 14, 1988. Born in 1918, Dr. Caton attended Indiana University School of Medicine, Indianapolis, receiving his medical degree in 1942. He was affiliated with the Medical Center at Princeton, and was a member of our Somerset County component, and of the AMA.

John F. Dixon, Jr. A retired member of our Somerset County component, John F. Dixon, Jr., MD, died on December 19, 1988. Born in Brooklyn, New York, in 1913, Dr. Dixon earned his medical degree from the Long Island College of Medicine in 1937. After an internship and residency, Dr. Dixon served as a major in the U.S. Army until 1946. After resigning from his position as school physician in Dryden, New York, he received his New Jersey medical license in 1955. A family practitioner, Dr. Dixon was a diplomate of the American Board of Family Practice, a fellow of the American Academy of Family Practice, and a member of the American Medical Association.

Lester W. Eisenstodt. Retired from the practice of medicine in 1986, Dr. Lester Warner Eisenstodt, MD, died in October 1988. Born in 1916 in Newark, Dr. Eisenstodt received his medical degree from the University of Lausanne, Switzerland, in 1941 and his New Jersey license in 1942.

Dr. Eisenstodt was a plastic surgeon with a private practice in Newark; he was affiliated with St. Elizabeth Hospital, Alexian Brothers Hospital, both in Elizabeth, and Newark Beth Israel Medical Center. A board certified physician, Dr. Eisenstodt was a fellow of the International College of Surgeons and a retired member of the Medical Society of New Jersey Essex County component.

Frederick D. Fahrenbruch. Retired since 1985 after 58 years as a family physician and gynecologist, Frederick Daniel Fahrenbruch, MD, died on December 17, 1988. A 1901 Oxford, Nebraska native, Dr. Fahrenbruch was graduated from the University of Nebraska College of Medicine, Omaha, in 1925. He was a staff member of Memorial Hospital of Burlington County, Mount Holly, where he founded the obstetrics department, and served as department chief for 15 years. School physician for Lumberton, Hainesport, and Smithville, Dr. Fahrenbruch was a member of the Philadelphia Obstetrical Society, of the New Jersey State Obstetrical and Gynecological Society, of the AMA, and of our Burlington County component. During World War II, he was a captain in the U.S. Army medical corps. For 50 years of service as a physician, Dr. Fahrenbruch received the Medical Society of New Jersey Golden Merit Award in 1975.

Solomon Joseph. Retired orthopedic surgeon Solomon Joseph, MD, died on November 21, 1988, at the age of 76. Born in New York City, Dr. Joseph received his medical degree at Dalhousie University Faculty of Medicine, Halifax, Nova Scotia. A diplomate in surgery and a fellow of the American College of Surgeons, Dr. Joseph was the emergency room chief of Englewood Hospital until his retirement in 1984, and past-presi-

dent of the Hospital's medical staff. Dr. Joseph was a United States Army veteran of World War II, and was a member of the Medical Society of New Jersey Bergen County component.

Robert E. Verdon. Retired in 1982 from his family practice in Cliffside Park, Robert Edward Verdon, MD, died on December 30, 1988, at the age of 76. Born in Hoboken, Dr. Verdon earned his medical degree at the University of St. Louis, Missouri, in 1938. He became affiliated with Hackensack Medical Center; Bergen Pines County Hospital, Paramus; Riverside General Hospital, Secaucus; and St. Mary Hospital, Hoboken, where he was director of the residency program. A diplomate in family practice and a past president of the New Jersey Academy of Family Practice, Dr. Verdon was a member of the Medical Society of New Jersey Bergen County component, and of the American Medical Association. He served the U.S. Army medical corps during World War II as a first lieutenant.

Alexander J. Wishbow. A member of our Morris County component, Alexander J. Wishbow, MD, died on January 9, 1989, at the age of 66. Born in Jersey City, Dr. Wishbow earned his medical degree from New York University School of Medicine in 1947, and received his license to practice in New Jersey in 1948. During his career as an ophthalmologist, Dr. Wishbow was affiliated with Morristown Memorial Hospital and All Souls Hospital, both in Morristown. A member of the American Board of Ophthalmology and of the American Medical Association, Dr. Wishbow also was a fellow of the American Academy of Otolaryngology and Ophthalmology. Dr. Wishbow served as a lieutenant in the U.S. Navy from 1944 to 1945 and from 1951 to 1953.

EDITORIAL CRITERIA

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. All material published is copyrighted by MSNJ.

Content. The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevant to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made to an audience in New Jersey.

Assignment of Copyright. In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statement accompany-

ing material offered to *NEW JERSEY MEDICINE* must contain the following language and must be signed by all authors.

"In consideration of *NEW JERSEY MEDICINE* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *NEW JERSEY MEDICINE*.

Specifications. Submit two manuscripts that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods should be identified.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 30-word abstract.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission must be submitted.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

References should not exceed 35 citations except in review articles, and should be cited consecutively by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in numerical order. The style of *NEW JERSEY MEDICINE* is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

Publication Policy. Receipt of each manuscript will be acknowledged; the paper will be referred to the Editorial Board. The final decision is reserved for the editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. Galley proofs will be submitted to the author for correction.

Reprint Orders. Reprints may be ordered after the author is notified that the article has been selected for a specific issue. A check for the cost of reprints must accompany that order.

Communications. All communications should be sent to the editor, *NEW JERSEY MEDICINE*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

FOR RENT

Fully furnished Medical Doctor's office, ideal for beginning practice. On principal street in East Rutherford, NJ, 194 Carlton Avenue. In vicinity of University of Medicine & Dentistry of Newark, Passaic General Hospital & St. Mary's Hospital, Passaic.

Office includes 7 large rooms covering entire first floor—Reception Room, Nurse's Office, Doctor's Consulting Room, 3 Examining Rooms, Powder Room & Medical Room with sink, refrigerator & Autoclave. Furnished: examining tables, desks, chairs, file cabinets & some medical equipment. Ample closets & 3 separate entrances. Immediate availability. \$975. p/mo. Nego.

Call 201-507-1766, 201-935-7041

BUYING OR SELLING A PRACTICE?

It is one of the largest and most important business transactions you will ever make. You can handle it yourself, spend a great deal of time and energy trying to make such a sale work, and risk not getting a fair market price. Or, you can turn to EPSTEIN PRACTICE BROKERAGE, INC. Our brokerage service includes consultation, appraisal, screening, and negotiation of terms. Come join our group of satisfied clients.

EPSTEIN PRACTICE BROKERAGE, INC.

16 West Palisade Avenue
Englewood, New Jersey 07631
(201) 568-4933

INVEST IN APARTMENTS

CPA, 10 years experience, seeking investors to jointly acquire apartments located in recovering urban areas of New Jersey. For more information, call John Huber at (201) 292-5073, or write to JH Properties, P.O. Box 5704, Parsippany, NJ 07054.

POSITION WANTED

PHYSICIAN PRACTICE MANAGER

Experienced health care administrator seeks challenging position. Proven skills in:

Administration/Planning/Fiscal Management
Innovative Problem Solving
Leadership
Marketing
Effective Communication

Please send inquiries to:

Box No. 297
New Jersey Medicine
370 Morris Avenue
Trenton, NJ 08611

HOME/OFFICE FOR SALE

Prestigious Shorefront Community—Sea Girt—Established medical office, 3 treatment rooms with 4 bedroom Colonial, excellent location for family and practice. Call for further details.

Offered at \$615,000

HENRY S. SCHWIER, INC.
(201) 449-6200.

EXCEPTIONAL MOTHER/DAUGHTER WITH PROFESSIONAL OFFICE

Exquisite 11 rm split level home in prime Montclair Heights. Feature: 4 br & 3.5 ba, 2 kit, office, sophisticated burglar-fire- & medical alert system, 2 car gar & much more! Easy commute to Manhattan! Call for further details. \$399,900 172-1067

**Weichert
Realtors**

201-779-1900



OCEAN FRONT YEAR ROUND LIVING, or VACATION/RENTAL/INVESTMENT PROPERTY IN ORTLEY BEACH, N.J.

New 3 bedroom penthouse Condo, 2 full baths, full European kitchen, cathedral ceilings with 3 skylights in living/dining area, fireplace in living area, utility/laundry room, elevator, forced air gas heat, central air, 1 deck with bay view, one deck ocean front and a 3rd observation deck on roof, 3 parking spaces, 1,600 sq. ft. living space, private beach community, a total of only 10 units in this condominium.

LOW \$400,000 RANGE

For further information, call 201-793-6704.



CAPITOL COMMENTARY

GENERIC TUG OF WAR

Physicians are caught in the middle of a tug of war between supporters and opponents of a proposed change in the state's law governing generic drug dispensing.

At issue is Senator Richard Codey's S-3440, which in legislative vernacular has become known as the "one line prescription" bill. The measure would require physicians and other prescribers to write either "brand necessary" or "brand medically necessary" on their prescriptions in order to instruct pharmacists not to substitute a generic drug for a brand name. For prescriptions telephoned to pharmacies, S-3440 would require a generic drug to be dispensed unless the prescriber states to the contrary.

The current generic drug substitution law, enacted a dozen years ago, changed the format of prescription blanks to include the words "substitution permissible" or "do not substitute" on the form, with the prescriber writing his or her initials next to the desired option. Under S-3440, that procedure no longer would apply.

Senator Codey's bill has polarized the pharmacy lobby, with such chain stores as Rite Aid and Thrift Drugs pressing for its passage while smaller, independent pharmacies represented by the New Jersey Pharmaceutical Association working to defeat it. Apparently, chain stores receive significant discounts when buying generic drugs in large quantities. Also working against the bill are a number of the state's large pharmaceutical houses which enjoy considerable clout in the Legislature. Generic drug manufacturers, of course, support the bill, but their lobbying presence here is insignificant when compared to the state's pharmaceutical industry.

Interestingly, both sides have asked the Society to become actively involved in the issue, convinced that medicine's position sufficiently would tip the scales to guarantee passage or defeat of S-3440. At present, the Society is remaining neutral on the bill, its major concern being only to assure that whatever the physician prescribes will be dispensed.

For his part, Senator Codey, the powerful chairman of the Senate Health Committee, explains that he agreed to sponsor the bill because he is convinced it will encourage physicians and others to give more consideration to generics, and thus save consumers—particularly senior citizens—as much as \$100 to \$500 a year. A recent survey of pharmacies by the New Jersey Public Interest Group, a "citizens' lobby," found generic drugs to be from 55 percent to 234 percent less expensive than their brand name counterparts.

Senator Codey's sponsorship of the bill virtually guarantees its release from the Health Committee, which was scheduled to act on the measure at its May 22 meeting. After that, the fate of S-3440 may depend on the effectiveness of the lobbying efforts of the various interest groups. The bill has no counterpart in the Assembly.

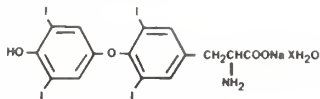
LEVOXINE[®]

(LEVOTHYROXINE SODIUM TABLETS, USP)

FOR ORAL ADMINISTRATION

DESCRIPTION:

Each LEVOXINE (Levothyroxine Sodium, USP) tablet contains synthetic crystalline levothyroxine sodium (L-thyroxine). L-thyroxine is the principal hormone secreted by the normal thyroid gland. Chemically, L-thyroxine is designated as L-tyrosine, O-(4-hydroxy-3, 5-diiodophenyl) - 3,5-diiodo-, monosodium salt, hydrate. The molecular formula is $C_{15}H_{10}I_4NNaO_4$ and the structural formula is:



CLINICAL PHARMACOLOGY:

The principal effect of thyroid hormones is to increase the metabolic rate of body tissues.

The thyroid hormones are also concerned with growth and development of tissues in the young.

The major thyroid hormones are L-thyroxine (T_4) and L-triiodothyronine (T_3). The amounts of T_4 and T_3 released from the normally functioning thyroid gland are regulated by the amount of thyrotropin (TSH) secreted from the anterior pituitary gland. T_4 is the major component of normal thyroid gland excretions and is therefore the primary determinant of normal thyroid functions. T_4 acts as a substrate for physiologic deiodination to T_3 in the peripheral tissues. The physiologic effects of thyroid hormones are mediated at the cellular level primarily by T_3 .

LEVOXINE (L-thyroxine) tablets taken orally provide T_4 which upon absorption can not be distinguished from T_4 that is secreted endogenously.

INDICATIONS AND USAGE:

LEVOXINE (L-thyroxine) tablets are indicated as replacement or supplemental therapy for diminished or absent thyroid function (e.g., cretinism, myxedema, nontoxic goiter or hypothyroidism) generally including the hypothyroid state in children, in pregnancy and in the elderly) resulting from functional deficiency, primary atrophy, from partial or complete absence of the gland or from the effects of surgery, radiation or antithyroid agents. Therapy must be maintained continuously to control the symptoms of hypothyroidism.

CONTRAINDICATIONS:

L-thyroxine therapy is contraindicated in thyrotoxicosis, acute myocardial infarction and uncorrected adrenal insufficiency.

WARNINGS:

Drugs with thyroid hormone activity, alone or together with other therapeutic agents, have been used for the treatment of obesity in euthyroid patients, doses within the range of daily hormonal requirements are ineffective for weight reduction. Larger doses may produce serious or even life-threatening manifestations of toxicity, particularly when given in association with sympathomimetic amines such as those used for their anorectic effects.

PRECAUTIONS:

General — Caution must be exercised in the administration of this drug to patients with cardiovascular disease. Development of chest pains or other aggravation of the cardiovascular disease requires a reduction of dosage.

Information For The Patient — Patients on thyroid preparations and parents of children on thyroid therapy should be informed that:

1. Replacement therapy is to be taken essentially for life, with the exception of cases of transient hypothyroidism, usually associated with thyroiditis, and in those patients receiving a therapeutic trial of the drug.
2. They should immediately report during the course of therapy any signs or symptoms of thyroid hormone toxicity, e.g., chest pain, increased pulse rate, palpitations, excessive sweating, heat intolerance, nervousness, or any other unusual event.
3. In case of concomitant diabetes mellitus, the daily dosage of antidiabetic medication may need readjustment as thyroid hormone replacement is achieved. If thyroid medication is stopped, a downward readjustment of the dosage of insulin or oral hypoglycemic agent may be necessary to avoid hypoglycemia. At all times, close monitoring of urinary glucose levels is mandatory in such patients.
4. In case of concomitant oral anticoagulant therapy, the prothrombin time should be measured frequently to determine if the dosage of oral anticoagulants is to be readjusted.
5. Partial loss of hair may be experienced by children in the first few months of thyroid therapy, but this is usually a transient phenomenon and later recovery is usually the rule.

Laboratory Tests — The patient's response to thyroid replacement may be followed by laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels.

Drug Interactions — In patients with diabetes mellitus, addition of thyroid hormone therapy may cause an increase in the required dosage of insulin or oral hypoglycemic agents. Therefore, patients with diabetes mellitus should be observed closely for possible changes in antidiabetic drug dosage requirements.

Patients stabilized on oral anticoagulants who are found to require thyroid replacement therapy should be watched very closely when therapy is started. If a patient is truly hypothyroid, it is likely that a reduction in anticoagulant dosage will be required. No special precautions appear to be necessary when oral anticoagulant therapy is begun in a patient already stabilized on maintenance thyroid replacement therapy.

Cholestyramine binds both T_4 and T_3 in the intestine, thus impairing absorption of these thyroid hormones. In vitro studies indicate that the binding is not easily removed. Therefore, four to five hours should elapse between administration of cholestyramine and thyroid hormones.

Estrogens tend to increase serum thyroxine-binding globulin (TBG). In a patient with a non-functioning thyroid gland who is receiving thyroid replacement therapy, free thyroxine may be decreased when estrogens are started thus increasing thyroid requirements. However, if the patient's thyroid gland has sufficient function the decreased free thyroxine will result in a compensatory increase in thyroxine output by the thyroid. Therefore, patients without a functioning thyroid gland who are on thyroid replacement therapy may need to increase their thyroid dose if estrogens or estrogen containing oral contraceptives are given.

Drug/Laboratory Test Interactions — The following drugs or moieties are known to interfere with laboratory tests performed on patients taking thyroid hormone: androgens, corticosteroids, estrogens, oral contraceptives containing estrogens, iodine-containing preparations, and the numerous preparations containing salicylates.

1. Changes in TBG concentration should be taken into consideration in the interpretation of T_4 and T_3 values. In such cases, the unbound (free) hormone should be measured. Pregnancy, estrogens, and estrogen-containing oral contraceptives increase TBG concentrations. TBG may also be increased during infectious hepatitis. Decreases in TBG concentrations are observed in nephrosis, acromegaly and after androgen or corticosteroid therapy. Familial hyper- or hypo-thyroxine-binding-globulinemias have been described. The incidence of TBG deficiency approximates 1 in 9000. The binding of thyroxine by thyroid-binding prealbumin (TBPA) is inhibited by salicylates.

2. Medical or dietary iodine interferes with all in vivo tests of radio-iodine uptake, producing low uptakes which may not be reflective of a true decrease in hormone synthesis.

3. The persistence of clinical and laboratory evidence of hypothyroidism in spite of adequate dosage replacement indicates either poor patient compliance, poor absorption, excessive fecal loss, or inactivity of the preparation. Intracellular resistance to thyroid hormone is quite rare.

Carcinogenesis, Mutagenesis, And Impairment

Of Fertility — A reportedly apparent association between prolonged thyroid therapy and breast cancer has not been confirmed and patients on thyroid for established indications should not discontinue therapy. No confirmatory long-term studies in animals have been performed to evaluate carcinogenic potential, mutagenicity, or impairment of fertility in either males or females.

Pregnancy — Category A — Thyroid hormones do not readily cross the placental barrier. The clinical experience to date does not indicate any adverse effect on fetuses when thyroid hormones are administered to pregnant women. On the basis of current knowledge, thyroid replacement therapy to hypothyroid women should not be discontinued during pregnancy.

Nursing Mothers — Minimal amounts of thyroid hormones are excreted in human milk. Thyroid is not associated with serious adverse reactions and does not have a known tumorigenic potential. However, caution should be exercised when thyroid is administered to a nursing woman.

Pediatric Use — Pregnant mothers provide little or no thyroid hormone to the fetus. The incidence of congenital hypothyroidism is relatively high (1:4,000) and the hypothyroid fetus would not derive any benefit from the small amounts of hormone crossing the placental barrier. Routine determinations of serum (T_4) and/or TSH is strongly advised in neonates in view of the deleterious effects of thyroid deficiency on growth and development.

Treatment should be initiated immediately upon diagnosis, and maintained for life, unless transient hypothyroidism is suspected; in which case, therapy may be interrupted for 2 to 8 weeks after the age of 3 years to reassess the condition. Cessation of therapy is justified in patients who have maintained a normal TSH during those 2 to 8 weeks.

ADVERSE REACTIONS:

Adverse reactions are due to overdosage and are those of induced hyperthyroidism.

OVERDOSAGE — Excessive dosage of thyroid medication may result in symptoms of hyperthyroidism. Since, however, the effects do not appear at once, the symptoms may not appear for one to three weeks after the dosage regimen is begun. The most common signs and symptoms of overdosage are weight loss, palpitation, nervousness, diarrhea or abdominal cramps, sweating, tachycardia, cardiac arrhythmias, angina pectoris, tremors, headache, insomnia, intolerance to heat and fever. If symptoms of overdosage appear, discontinue medication for several days and reinstitute treatment at a lower dosage level.

Laboratory tests such as serum T_4 , serum T_3 and the free thyroxine index will be elevated during the period of overdosage.

Complications as a result of the induced hypermetabolic state may include cardiac failure and death due to arrhythmia or failure.

TREATMENT OF OVERDOSAGE — Dosage should be reduced or therapy temporarily discontinued if signs and symptoms of overdosage appear. Treatment may be reinstituted at a lower dosage. In normal individuals, normal hypothalamic-pituitary-thyroid axis function is restored in 6 to 8 weeks after thyroid suppression.

Treatment of acute massive thyroid hormone overdosage is aimed at reducing gastrointestinal absorption of the drugs and counteracting central and peripheral effects, mainly those of increased sympathetic activity. Vomiting may be induced initially if further gastrointestinal absorption can reasonably be prevented and barring contraindications such as coma, convulsions, or loss of the gagging reflex. Treatment is symptomatic and supportive. Oxygen may be administered and ventilation maintained. Cardiac glycosides may be indicated if congestive heart failure develops. Measures to control fever, hypoglycemia, or fluid loss should be instituted if needed. Antiadrenergic agents, particularly propranolol, have been used advantageously in the treatment of increased sympathetic activity. Propranolol may be administered intravenously at a dosage of 1 to 3 mg over a 10 minute period or orally, 80 to 160 mg/day, especially when no contraindications exist for its use.

DOSAGE AND ADMINISTRATION:

The goal of therapy should be the restoration of euthyroidism as judged by clinical response and confirmed by appropriate laboratory tests such as serum thyroxine (T_4), serum triiodothyronine (T_3), free thyroxine index and thyroid stimulating hormone (TSH) blood levels. The age and general condition of the patient and the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage.

In otherwise healthy adults, the recommended initial dose is 25 to 100 mcg (0.025 to 0.1 mg) daily, while the predicted full maintenance dose of 100 to 200 mcg (0.1 to 0.2 mg) daily may be achieved in two to three weeks.

In the elderly patient with long standing disease, evidence of myxedema, or evidence of cardiovascular dysfunction, the initial dose may be as little as 12½ mcg (0.0125 mg) per day. Incremental increases of 25 mcg (0.025 mg) per day at 3 to 4 week intervals may be instituted depending on patient response. It is the physician's judgement of the severity of the disease and close observation of patient response which determine the rate and extent of dosage increase.

In infants and children there is a great urgency to achieve full thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult. The recommended daily replacement dosage of L-thyroxine in childhood is: 0-1 years: 5-6 mcg/kg; 1-5 years: 3-5 mcg/kg; 6-12 years: 4-5 mcg/kg of body weight daily.

DOSAGE FORMS AVAILABLE:

LEVOXINE (L-thyroxine) tablets are supplied as oval, color coded, potency marked tablets in eleven strengths: 12½ mcg (0.0125 mg)—maroon, 25 mcg (0.025 mg)—orange, 50 mcg (0.05 mg)—white, 75 mcg (0.075 mg)—purple, 100 mcg (0.1 mg)—yellow, 112 mcg (0.112 mg)—rose, 125 mcg (0.125 mg)—brown, 150 mcg (0.15 mg)—blue, 175 mcg (0.175 mg)—turquoise, 200 mcg (0.2 mg)—pink and 300 mcg (0.3 mg)—green, in bottles of 100, 1000, unit dose cartons of 100 (1C strips of 10 each), and 500 mcg injectable (See injectable package insert).

**dp DANIELS
PHARMACEUTICALS, INC.**

2517 25th Avenue North
St. Petersburg, Florida 33713-3999



PROFESSIONAL LIABILITY

CLERGY SUIT DISMISSED

In a unanimous vote, the California Supreme Court held that neither the clergy nor others unlicensed as counselors or therapists could legally be held liable for failing to provide proper care for the people they advise. The case is said to be the first "clergy malpractice" suit ever brought in the United States. The ruling appears to confer broad legal protection in such cases to Boy Scout leaders, drug counselors, college dormitory advisers, and others who advise the emotionally troubled. The ruling came after eight years of counseling by pastors at the Grace Community Church of the Valley, in Sun Valley, California. Since the ruling was based on California rather than United States constitutional law, it is doubtful that any appeal to the United States Supreme Court is possible. (*The Church Around the World*, January 1989)

ISO STUDY ANALYZED CLAIM FILES

Some certain specific tort reforms could reduce payouts in large liability cases, ostensibly without diminishing plaintiffs' needs and rights, suggests a recent Insurance Services Offices (ISO) study.

ISO analyzed 13,000 commercial liability claim files with a bodily injury claim of more than \$25,000, both open and closed, that arose out of policies written in 1983; all claims, regardless of size, closed during the first week of August 1987; and bodily injury claims under \$25,000 against entities arising from 1983 policies. Medical malpractice claims were not included. ISO found that for the vast majority of claimants, their liability insurance compensation covered at least their medical costs, past and future wage losses, and rehabilitation costs. "On average, claimants received several times their compensable economic losses," ISO said. The study adjusted compensation on the basis of the claimant's share of fault, but "even when not fault-adjusted, claimants received an average of 2.5 times their economic loss." This finding suggests that many claimants receive a "substantial compensation for noneconomic damages. . . ." The second important finding is that a small number of claims accounts for the largest indemnity. In its analysis of claims for the first week of August 1987, ISO found that claims of \$25,000 or more represented only 9 percent of claims, but 76 percent of all compensation paid. The policy implication here is that tort reforms that target high-cost cases can be very important. Third, ISO verified that longer periods of litigation led to higher payouts. "The average compensation rose from \$12,000 for claims closed within 6 months after filing to \$77,000 for claims closed from 48 to 60 months after filing," ISO said. Three current tort doctrines contribute to higher claims costs, the evidence produced in the study shows: the "deep pockets" joint and several liability doctrine, prohibitions on reduction of awards by collateral source amounts, and punitive damage requests.

Although ISO avoided taking sides on policy issues, saying instead that its study "provides a firmer factual basis for debate," the mandate for certain tort reforms is clear. (*Medical Liability Monitor*, January 18, 1989, Volume 14, Number 1)

LEGAL CONSULTING FEE DECLARED VOID

The agreement between a plaintiff, her attorney, and a medical expert consulting business was rendered void and unenforceable by a New Jersey court, where a contingency fee payment to the consulting business was part of the contract. The court ruled that such an arrangement violates the public policy of the state of New Jersey, the professional code of ethics applicable to attorneys in that state, and ethical guidelines of the medical profession. The underlying medical liability action involved a birth injury claim against the obstetrician that delivered the plaintiff. The consulting service, JDMD, Inc., was retained by plaintiff's guardian and her attorney to review medical records, render an opinion, be deposed, and testify at trial, with expert witness fees to be computed at an hourly rate. However, according to the court, the method of payment of these hourly fees involved two "service charges." The first was an initial charge of \$500 due when the identity of the expert located by JDMD, Inc., was disclosed to the plaintiff and her attorney. The second service charge provided for a 6 percent contingent fee on the gross recovery upon successful disposition of the case by either settlement or verdict. This contingent fee, payable by the client, was in addition to the attorney's own contingent fee. Moreover, the plaintiff's attorney was required by the agreement to act as guarantor of the contingent fee payment to JDMD, Inc. The action against the obstetrician ultimately was settled. Reviewing the expert witness contingent fee arrangement, the court objected to it on a number of grounds. First, the court determined that it was contrary to the Current Opinions of the AMA's Council on Ethical and Judicial Affairs, which stated that a physician's fee should be calculated only on the value of the medical services provided. The court expressed concern for the danger of a physician "becoming more of an advocate and less of a healer."

Second, the court held that the contract was prohibited by an ethical opinion issued by the New Jersey Advisory Committee on Professional Ethics, which regulates attorney conduct in the state. The opinion reaffirmed that a physician's fee for providing medical-legal consultation should not be based on the outcome of the litigation and stated that attorneys should not assist in fostering a contingent fee arrangement with a doctor.

Third, the court noted that New Jersey's medical practice act prohibited physicians from charging a contingent fee where the medical services involved supporting a legal claim for damages. New Jersey Supreme Court Rules on fee arrangements also manifest a clear intent to prohibit anyone other than an attorney from charging a contingent fee; in addition, attorneys are prohibited from sharing their fee with anyone other than a licensed attorney.

Finally, the court reviewed its duty to safeguard the interest of minor plaintiffs by closely monitoring litigation settlements on their behalf and attendant fee arrangements. As the court stated, if photographers, accident reconstruction experts, investigators, and the like were permitted to charge on a contingent fee basis, only a miniscule portion of a recovery would be left for the injured plaintiff.

For these reasons, the court determined that it was obviously contrary to the public policy of the state of New Jersey and the expectation of its citizens to allow contingent fee agreements for medical expert witness services to stand. The fee agreement of JDMD, Inc., was declared void. (*Professional Liability Update*, November/December 1988)



EDITOR'S DESK

CONFLICT OF INTEREST OR CHAINSAW MASSACRE

Many of you are aware that Representative Fortney "Pete" Stark (D, California) proposes to ban physician referrals of Medicare patients to almost any entity where the physician has a financial interest. Forget the convenience, forget the savings, and forget the openness of disclosure between patient and doctor—patients must be protected, even if it hurts them.

We must agree that some physicians have abused the system. But the numbers are small and New Jersey laws, past and present, have limited the available venues for such practices and have mandated full disclosure in permitted areas. The medical profession, although it is shackled by legal restrictions, continues to monitor dubious activities and to promote adherence to traditional ethical medicine. We should agree to proper financial disclosure, both in the practice setting and in research.

It is ironic that a Washington legislator should be prescribing the rules applying to other people's ethics and conflicts of interest. The travails of Oliver North, John Tower, and Jim Wright are fresh in our minds, but they are only the newest in a continuing train of national governmental abuse. Do we really believe that the troubles of the aforementioned persons will halt the many ill-advised perks enjoyed by those in the hallowed halls, from taxpayer financed trips, to lobbyist-paid gifts, trips, and club memberships?

We also have misgivings about the widespread nepotism shown by politicians and bureaucrats in placing friends and relatives, in place of better qualified individuals, on the public payroll. We should be even more concerned that such dubious activities are widely condoned. One local politician proclaimed, in open forum, that good party workers always should be favored over the merely competent, talented, and accomplished. George Vecsey, in a *New York Times* column touching on the woes of the University of Kentucky basketball program, quoted a Commonwealth of Kentucky politician, who pronounced, in a statewide television program, "They have had their turn at the trough; now we want ours."

Of course, considering the University of Kentucky problems with the National Collegiate Athletic Association (NCAA), we also could dwell on the perfidy of college deans, presidents, and coaches in dealing with goals of higher education—but we will not. This topic receives sufficient publicity elsewhere.

Should we write about the lawyers and their "referral fees?" Perhaps some other time. And we shall also save the topic of Wall Street insiders for future consideration.

Do for-profit health plans have an intrinsic conflict of interest? Do HMOs, PROs, self-insuring corporate plans, and other types of managed care provide benefits based on the bottom line? If profits are jeopardized,

benefits must be curtailed. If benefits are curtailed, patients must suffer. And yet the government continues to favor such management schemes!

There is no excuse for anyone, including physicians, to rake in windfall profits at the expense of the American public. But the excesses of a few doctors pall in the face of the monumental misfeasance seen around us. As our friend, Jim Todd, expressed to the Congress, the Stark bill acts as a "chainsaw against the whole medical profession," and the medical profession itself, given the authority, could take "a scalpel to a few offending individuals."

Washington and Representative Stark should look to New Jersey for a more moderate and reasoned approach to conflict of interest. We are obliged to give full written disclosure to patients when we have a "significant beneficial interest" in a health care service to which we refer. We are not banned from making such referrals. In addition, the New Jersey Legislature has proposed a uniform code regarding conflict of interest by county, municipal, and public authority officials. It would cap the efforts already promoted by at least 170 of New Jersey municipalities. If only our national legislators would agree to survive or to perish under such guidelines!

The thought of another federal bureaucratic nightmare, to monitor compliance with the proposed law, should give pause to all thinking individuals. The Washington establishment has proved, too often, its inability to function effectively, economically, and expeditiously. It would be better for the powers-that-be to clean out their own sties and to deal with other, more egregious, areas of conflict of interest than those posed by physicians. The medical profession and the states, certainly New Jersey, are dealing quite well with conflict of interest problems, thank you, without deserving or needing the demeaning oppression of the Stark bill.

SKIN CANCER IN NEW JERSEY

Our special May 1989 issue on skin cancer in New Jersey now is available. This full color issue costs \$6.50 and must be prepaid. As guest editor, Christopher M. Papa, MD, wrote, "Teach the ways to recognize the early warning signs of cancer. Help the patient look and feel better, whether through the use of topical tretinoin sunscreens, or prompt surgical removal of early cancers. The patients will love you for it." Send your check or money order to *NEW JERSEY MEDICINE*, Two Princess Road, Lawrenceville, NJ 08648.

ANNUAL MEETING FOR MSNJ

In the July issue of *NEW JERSEY MEDICINE*, you will be able to read in its entirety, the Transactions from the Annual Meeting of the Medical Society of New Jersey. The meeting held at the end of April, considered reports from the councils and committees of MSNJ, as well as resolutions and informational reports. Don't miss this complete section, detailing the opinions and actions of your Society.

CME IN NEW JERSEY

This fall, *NEW JERSEY MEDICINE* will be presenting a special issue on continuing medical education. The purpose of this publication will be to highlight various aspects of continuing medical education as it pertains to New Jersey practitioners. Topics to be included are education and computers, groups that influence CME in New Jersey, and innovations and future trends in the field. The guest editor of this special edition will be Alan J. Lippman, MD.



BOOK REVIEWS

SYMPTOMS AND SIGNS IN INFANTS, CHILDREN, AND ADOLESCENTS

Paul S. Bellet, MD. Philadelphia, PA, Lea & Febiger, 1989. A useful niche for the resident, student, or young physician interested in an approach to differential diagnosis of common problems encountered in pediatrics is offered by this book. Dr. Bellet has listed 76 problems beginning with abdominal mass and ending with wheezing. For each problem, he provides an approach with a clinical classification, a few features of each heading under that classification, and then a paragraph of comments about the diagnostic approach needed. For someone who desires a quick fix on one or more of the problems involved, this book is very useful. The style is traditional. Perhaps in a future edition, the author will convert the listings to algorithmic form—the basis of a more modern approach to differential diagnosis. I recommend this text for students, residents, and young practitioners interested in diseases of children. □ Avrum L. Katcher, MD

SYNOPSIS OF CARDIAC PHYSICAL DIAGNOSIS

Jonathan Abrams, MD. Philadelphia, PA, Lea & Febiger, 1989. This succinct monograph is a leaner, meaner version of its progenitor, *Essentials of Cardiac Physical Diagnosis*. The text is divided into two sections: Part I deals with basic principles of the cardiovascular examination including acoustical concepts, analysis of pulses, heart sounds, and murmurs. Part II looks at physical findings in the major, adult valvar lesions as well as hypertrophic cardiomyopathy and mitral valve prolapse. There is no discussion of congenital, coronary, or primary myocardial disease. The material is amply supported by excellent figures and drawings that illustrate the underlying physiologic principles using pressure pulses, phonocardiograms and Doppler echocardiograms. The book is replete with a large number of informative tables which summarize little-known facts about well-known entities. These include such clinically useful synopses as causes of pulsus paradoxus, differential features of precordial impulses, clinical correlates of the third heart sound, characteristics of organic as opposed to innocent ejection murmurs, contrasting findings in acute and chronic mitral regurgitation, and noncardiac signs of tricuspid regurgitation. The italicized “practical points,” in reality clinical pearls, are the highlight of the text and are generously sprinkled throughout; they include such aphorisms as: the pulmonic valve ejection click softens with inspiration in contradistinction to all other right-sided acoustic phenomena; a loud systolic murmur may be heard in severe aortic regurgitation in the absence of coexisting aortic stenosis; and a third heart sound and mid-diastolic murmur in severe mitral regurgitation do not necessarily indicate mitral stenosis nor left ventricular failure. Clearly, this wonderful, little book meets its goal of providing a solid background in cardiovascular physical diagnosis so that maximal diagnostic information may be obtained prior to extensive and expensive testing. Packaged to make it “accessible and portable” and priced to make it affordable, this book will inform and fascinate medical students, house officers, and even experienced cardiologists. I recommend it enthusiastically. □ Edwin L. Rothfeld, MD

YOCON®

YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

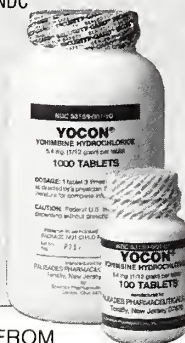
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE EXCLUSIVELY FROM
**PALISADES
PHARMACEUTICALS, INC.**

219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

EMC*EXPRESS™ submits claims
to these insurance carriers:

Blue Cross and Blue Shield of New Jersey-Private
Blue Cross and Blue Shield of Pennsylvania-
Medicare Part B

NEIC ACTIVE PARTICIPANTS

Aetna
Benefit Trust Life
Confederation Administration
Confederation Life
Connecticut General
Equicor
John Hancock
Great Southern Life
Guardian Life
Life of Georgia
Metropolitan Life
The New England
Pacific Mutual
Philadelphia American
Philadelphia Life
Principal Mutual Life
State Mutual Life Assurance
The Travelers

PRIVATE HEALTHCARE SYSTEMS

ACTIVE PARTICIPANTS

Benefit Trust Life
Business Men's Assurance
Central Life Assurance
CNA Insurance Companies
Claims Administration Corporation
Confederation Life
Crown Life
General American Life
Great-West Life
The Guardian Life
Jefferson-Pilot
Mony Financial Services
The Mutual Benefit Life
The New England
Phoenix Mutual Life
State Mutual Life
Time Insurance
Washington National Life
Western Life

The following vendors have incorporated the
EMC*EXPRESS™ system into their physician
practice management software:

SYSTEM VENDORS

Advanced Medical Office Systems (AMOS)	209-466-1807
Alcon	1-800-225-5489
Anson Systems, Inc.	312-564-8310, x500
Artificial Intelligence	1-800-533-8902
The Cactus Medical Group, Ltd	1-800-876-9495
CYMA/McGraw Hill	1-800-292-2962
DARO Associates	914-835-3645
GSR Systems, Inc.	1-800-426-9478
Healthcare Communications	402-489-0391
LDS	913-492-5700
Mid-Atlantic ICS, Inc.	1-800-772-2842
MOS, Inc.	1-800-323-6671
Physician Micro Systems	206-441-8490
Physicians' Office Computer	213-603-0555
PRISM Data Systems	1-800-223-3828
ProVision, Inc.	1-800-772-2847
RLI Professional Technologies, Inc.	1-800-447-2205
Santiago Data Systems, Inc.	1-800-652-3500
UNIVAIR, Inc.	314-426-1099
Westland Software House, Inc.	1-800-423-5880

SERVICE BUREAUS

Control-O-Fax	319-234-4651
Also Service by:	
Mifax Service and Systems	
Creative Systems	
Systems and Services	
PRODATA	1-800-PRODATA

You're looking at one of the most outdated procedures in the medical profession.

The Raphan Medical Group
4399 Hamlin Street Austin, Texas 78746



Henderson Insurance Co.
Claims Dept.
53-30 70th Street
Maspeth, New York 11378

It's costly, and it's painfully slow.

Yet thousands of doctors are still in the practice of mailing their insurance claims.

A procedure that has some rather unpleasant side effects. Such as costly administrative expenses, added paperwork, slower claims turnaround and worst of all, slower cash flow.

Fortunately, GTE Health Systems has a painless alternative.

Our EMC*EXPRESS™ system.

Many physicians' software vendors have incorporated EMC*EXPRESS™ into their software. And once it's part of the complete software package, the claims information you put in the computer is automatically edited for errors and omissions.

Then, with a single local telephone call, the claims data is sent to the EMC*EXPRESS™ network where it's transmitted to the insurance company's computer.

And all this takes place in a matter of minutes.

Something the postal service would have trouble doing.

But then again, who could keep up with GTE?

*Another solution to your information challenges from
GTE Information Services.*

GTE Health
Systems

THE POWER IS ON



LETTERS & VIEWPOINTS

ASSEMBLY FOR HEALTH DECISIONS

We were privileged to work with the group of dedicated, concerned, and informed people who collaborated to produce the special issue on biomedical ethics in January 1989. The diversity of the efforts documented and the variety of problems addressed speaks more eloquently than we can about the pervasive and serious nature of ethical issues in medical affairs today. Due to the passage of time and the rapid evolution of events, the current activities and contributions of one organization were not reflected adequately. This letter is designed to remedy that unintentional oversight.

A few years ago, after the Quinlan case first brought the consideration of ethical matters forcibly to the attention of New Jersey residents, a small group of concerned and caring people banded together to form the Citizens' Committee on Biomedical Ethics. This group, which included people both inside and outside the medical professions, established three goals: dissemination of factual information to the public to acquaint them with the issues and support them in forming opinions; collection of public opinion from a representative spectrum of New Jersey residents on the most critical and sensitive issues as they developed; and the recommendation of possible courses of action that New Jersey medical institutions, courts, and the state government might wish to consider.

These objectives were not pursued to develop some preprogrammed agenda of "solutions" but rather to stimulate public thinking and debate so the principal problems and the various approaches that might apply to them would be clarified. It is our belief that the Committee's work had a major impact on the decision of the Legislature to establish a Commission to investigate these matters in 1985. It also is clear that their work has been a major contribution to that body to assist it in framing the issues and encouraging it in its difficult work of developing legislative recommendations.

Although not enough medical professionals chose to participate in the work of the Committee in the past, the efforts of the ones who did have been invaluable. They brought to the analysis and debate of these very complex matters technical expertise, practical experience, and the humane outlook that distinguishes the best of the profession. The contributions of these dedicated people will continue to make the work of the Committee more relevant and effective.

The Committee has adopted its second program, the Assembly For Health Decisions. The change in name is not merely symbolic but signals what is intended to be a significantly augmented mission. In addition to information, analysis, opinion research, and debate, it is intended that the Assembly begin the process of trying to forge a public decision mechanism. The purpose of this is to enable the citizens of the state not only to express their opinions but take an active role in the development of legal policies that sooner or later affect every person. Once again, the "decisions" to be made are not decided by some group of appointees,

but rather must be generated from the public examination of the possible courses of action open to us.

This letter is to urge in the strongest possible way the greater participation by medical professionals—doctors, nurses, technicians, and administrators—in this work. The advantages of having people with such training and experience already have been cited but the advantages to the people who choose to contribute their efforts may not be so obvious: the Assembly provides a constant information flow of critical events and decisions that affect every person involved in medicine in the state, whether as patient or healer. The Assembly provides an environment within which complex and emotional issues can be aired and discussed in an unbiased and nonjudgmental way, free from the bureaucratic entanglements and legal snares that tend to surround them in the workplace. The Assembly provides a forum within which professionals and nonprofessionals can inform each other about the factors that impact medical interactions and the resulting decisions so that these difficult contacts may be handled more easily, more efficiently and, most important, more humanely. The Assembly is working in the public arena to formulate policies that will impact the practices of medicine in this state for years to come. For a person engaged in that practice to shirk the responsibility of shaping those decisions with professional knowledge and experience is unthinkable.

Your participation urgently is needed. Time is growing short and decisions will be made. Whether they are truly beneficial to patient and healer is a matter that rests very heavily in our hands. □ Joseph F. Fennelly, MD, and Richard B. Ellis, MD

EDITOR'S REPLY

Once again, we thank the writers for their continued efforts regarding biomedical ethics. Participation by the health care professional is essential; we no longer can afford to have a small cadre of "doers."

VIRAL DIAGNOSTIC LABORATORY

The UMDNJ-Robert Wood Johnson Medical School Viral Diagnostic Laboratory has completed its fifth year of operation. During 1988, 325 of 1,598 specimens yielded an identifiable virus for an isolation rate of 20 percent. Fifty-two percent of the isolates were herpes simplex virus. Cytomegalovirus re-emerged as the second most common virus isolated with 22 percent of the total isolates. This, in part, reflects the increase in patients in central New Jersey with human immunodeficiency viral infection. Respiratory syncytial virus dropped to third place in terms of isolation frequency, rotavirus was a close fourth, enterovirus was fifth, and influenza virus climbed to sixth place, reflecting the increased isolation rate toward the end of 1988, with adenovirus and herpes virus bringing up the rear. The Viral Diagnostic Laboratory increased the utilization of rapid diagnostic methodology for primary specimen testing and rapid culture confirmation including a herpes immunoperoxidase assay that our laboratory tested for nationwide utilization. In addition, a DNA probe assay for CMV culture confirmation was established; RSV enzyme immunoassays continued to be utilized both for rapid diagnosis on primary specimens and for culture confirmation. Rotavirus detection continues to be offered only in the rapid diagnostic format, with enzyme immunoassay. An adenovirus immunoassay will be utilized for the first time in calendar year 1989. Influenza viruses continue to be identified as hemadsorbers and are sent to the state health department for typing. There continues to be no rapid diagnostic or culture confirmation methodology for enteroviruses. Human immunodeficiency virus culture was

offered through the Viral Diagnostic Laboratory during calendar year 1988 and in 1989 will be offered by a separate HIV laboratory. The bottom line for the laboratory continues to be the desire to provide high-quality, rapid viral diagnostic services to hospitals and physicians in central New Jersey. □ Lawrence D. Frenkel, MD, professor, Departments of Pediatrics and Microbiology and director, Division of Immunology, Allergy, and Infectious Diseases

MEDICAL ETHICS BY OSMOSIS

Congratulations on the January 1989 issue of *NEW JERSEY MEDICINE* devoted to ethics and dedicated to Dr. Eckstein. The subject is of special interest to those of us in New Jersey because of the controversial cases (Quinlan, Conroy, Jobes, Farrell, and Peter) in our state and varying interpretations of the role of the ombudsman. I was particularly interested as medical director of Meadow Lakes, a C.C.R.C. where Dr. Eckstein once was medical director.

The Mercer County Medical Society meeting in February 1989 featured ethics with presentations by Michael Nevins, Paul Armstrong, and Russell McIntyre, all of whom stressed the importance of local ethics committees in dealing with institutional and patient issues in the field of ethics. Most of us in medicine had little or no formal training in ethical thinking or problem solving but approach these issues with highly charged emotional prejudices. We have a background of what I consider ethics by osmosis.

I recall no lecture on ethics in medical school. We learned that honesty is paramount. If you were too tired to do a CBC at 3 A.M. and reported a normal result, that would be totally unacceptable behavior. During internship, while rotating through the emergency room, we learned that the doctor should not moralize about the patient. All patients are equal and must be treated with the same skill and vigor, no matter what their background. We also learned that the patient comes first. When the possible criminal was critical from gunshot wounds and a medical team was doing all it could to save him, the sheriff's deputy who intruded himself into the process to obtain legal information from the patient was asked to leave. If he did not withdraw, he was physically removed.

As we matured in practice, we became more aware of our role as public servants with clear obligations to our patients. We were the patient's chief ombudsman. We had no right to force treatment on a patient against his will. We should not abandon a patient whom we had agreed to treat, but if a patient refused what we considered an essential treatment, we could ask them to transfer to the care of another physician. If, on the other hand, a patient insisted on a form of treatment morally or ethically unacceptable to the physician, he might ask the patient to find another doctor and assist in a smooth transfer of care.

With this patchwork ethics background, which varies from doctor to doctor, many of us now are serving on ethics committees. This ongoing educational experience will be valuable. Regardless of recommendations by an ethics committee, final decisions about patient care must remain with the physician, the patient, and the patient's relatives or advocates. Until I can be convinced otherwise, I believe we must act in good faith and do what we consider ethically right in the best interests of our patients, no matter what the legal consequences. □ Kent Young, MD

LETTERS TO THE EDITOR

Address all letters: Editor, *NEW JERSEY MEDICINE*, Two Princess Road, Lawrenceville, NJ 08648.

Golden Merit Award Recipients

At ceremonies held on April 28, 1989, during the 223rd Annual Meeting of the Medical Society of New Jersey, the following physicians received MSNJ's Golden Merit Award indicating they held the degree of Doctor of Medicine for 50 years.

Atlantic County

Raphael A. Levin, MD Jefferson 1939
Charles Allen Saseen, MD Hahnemann 1939

Bergen County

Joseph Philip Catania, MD . New York Medical 1939
Vincent Charles D'Agati, MD NYU 1939
Herbert E. Fitch, Jr, MD Vermont 1939
Daniel L. Goldstein, MD NYU 1939
William Lucius Palazzo, MD Long Island 1939
Frank John Schaberg, MD Columbia 1939
Howard Harvey Schlossman, MD St. Louis 1939
Simeon Siegel, MD Glasgow 1939
S. Harvey Sklar, MD Beirut 1939

Anthony Victor Stassi, MD Cincinnati 1939
Howard Charles Tobey, MD Long Island 1939
Nelson Clark Walker, MD Long Island 1939

Camden County

Stanley Philip Bernell, MD NYU 1939
Mario Armand Cinquino, MD Hahnemann 1939
George Pfahler Keefer, MD Pennsylvania 1939
Anthony Joseph Repici, MD Jefferson 1939
John Philip Rudolph, MD Jefferson 1939

Cape May County

Robert Alden Cornwell, MD Jefferson 1939

GOLDEN MERIT AWARD RECIPIENTS

Samuel C. Ingraham, 2nd, MD Pennsylvania 1939

Essex County

George Alterbaum, MD Glasgow 1939
 Jules Edgar Baime, MD Cincinnati Eclectic 1939
 Louis Bender, MD Hahnemann 1939
 Ruth Virginia Berney, MD Western Ontario 1939
 Jules H. Bromberg, MD Northwestern 1939
 Frederick J. Dann, MD New York Medical 1939
 Emilio Frederick De Lia, MD Loyola 1939
 Harry H. Farb, MD Berlin 1939
 Lawrence Gilbert, MD Scotland 1939
 Bernard R. Goldberg, MD Western Ontario 1939
 Roger A. Greco, MD Naples 1939
 S. Jerome Greenfield, MD Yale 1939
 Charles J. Grubin, MD New York Medical 1939
 Olga Haller, MD Heidelberg 1939
 John Insabella, MD St. Louis 1939
 Benjamin Beryl Jacobs, MD Edinburgh 1939
 Alexander Keyssar, MD Paris 1939
 Henry L. Kuperman, MD ... Cincinnati Eclectic 1939
 Herman Kupper, MD Bologna 1939
 Nicholas Anthony Maggio, MD Loyola 1939
 Julia Agnes McNeely, MD NYU 1939
 Chester Joseph Modeski, MD Boston 1939
 Humbert L. Riva, MD Pittsburgh 1939
 Mark A. Roston, MD Pavia 1939
 Irvin E. Sadoff, MD Louisville 1939
 F. Russell Sandford, MD Long Island 1939
 William S. Schram, MD Scotland 1939
 Stanley Stellar, MD Tufts 1939
 George Fey Stoll, MD Pennsylvania 1939
 Paul Strassburger, MD Pennsylvania 1939
 William Alzor Sturman, MD Syracuse 1939

Gloucester County

Frederick John Faux, MD Jefferson 1939

Hudson County

Joseph Francis Corless, MD Georgetown 1939
 Mario Galileo Del Baglivo, MD Rome 1939
 Frank William Mahoney, MD Edinburgh 1939
 Samuel J. Megibow, MD Minnesota 1939
 Sarah S. Schenker, MD Cincinnati Eclectic 1939
 Gerta Schwarz, MD Basel 1939
 John Schwarz, MD Basel 1939

Hunterdon County

Michael Anthony Colella, MD Hahnemann 1939

Mercer County

Ambrose Peter Clunan, MD Jefferson 1939
 William J. Dougherty, MD Georgetown 1939
 Erwin Preston Sacks-Wilner, MD .. Hahnemann 1939
 Sebastian J. Vento, MD New York Medical 1939

Middlesex County

Francis Guy Casey, Jr, MD Cornell 1939

Joseph L. Ecker, MD Prague 1939
 William Drexler Van Riper, MD Temple 1939

Monmouth County

Lester Alfred Barnett, MD .. George Washington 1939
 Milton Bregman, MD Edinburgh 1939
 Edward Dengrove, MD Edinburgh 1939
 Armand S. Mazie, MD Bologna 1939
 N. Craig Roberts, MD Tulane 1939
 Sica Littman Schmaier, MD Strasbourg 1939
 Herman O. Wiley, MD Howard 1939

Morris County

Dora G. Cook, MD Woman's Medical 1939
 Ella F. Cummins, MD Albany 1939
 Carl Kampton Friedland, MD Pennsylvania 1939
 Salvatore Giordano, MD Marquette 1939
 Eugene Nargiello, MD Warsaw 1939

Ocean County

Gene B. Mauceri, MD Georgetown 1939

Passaic County

Elmer J. Cichon, MD St. Louis 1939
 Otto Eisert, MD Glasgow 1939
 Vincent Feliciano, MD Georgetown 1939
 Isadore Herman, MD New York University 1939
 Marion Francis Kaletkowski, MD ... Georgetown 1939
 Arthur C. Lawrence, MD Louisville 1939
 David Levy, MD Cincinnati 1939
 Charlotte Lomova, MD Prague 1939
 Vincenzo Raffaele Onorato, MD Naples 1939
 Theodore Pollock, MD Emory 1939
 Louis Samuel Saco, MD Georgetown 1939
 Vincent Antonio Scialli, MD Hahnemann 1939
 Matthew John Sheft, MD Loyola 1939

Somerset County

William Felix Jones, MD Temple 1939
 Edwin Davis Merrill, MD Hahnemann 1939
 Albert Francis Misko, MD NYU 1939

Union County

Igino Grossi, MD Rome 1939
 Max Mortimer Mendelson, MD Rome 1939
 Stephen Repta, MD Jefferson 1939
 Frank R. Romano Sr, MD ... New York Medical 1939
 Oscar Rozett, MD Budapest 1939
 Mario Joseph Scalessa, MD Georgetown 1939
 Max Shapiro, MD Turin 1939
 Anthony Sordill, MD Bologna 1939
 Seymour Edward Spivack, MD NYU 1939
 William Wolf Weissberg, MD Cincinnati 1939
 Jack Harold Wolfsie, MD NYU 1939

Warren County

Frank J. Bartolini, MD Georgetown 1939

Inaugural Address: Because We Care

PAUL J. HIRSCH, MD

It is a special privilege and honor for me to stand before you today, to introduce to you, the next president of the Medical Society of New Jersey.

Our medical profession, and the Medical Society, are being challenged by these extraordinary times. The challenges come to us from many directions including our patients, the public in general, the media, government, insurance companies, as well as from within our own profession.

At the same time, when the environment in which we practice medicine is in its greatest state of flux, there is an expansion of technology and a greater need to acquire ongoing knowledge. As physicians, we have learned to create solutions to complex problems, and have learned that with this challenge there exists the opportunity to positively affect our future.

We seek to preserve the ability to deliver quality care in what is becoming a more adversarial environment.

We hope to maintain the ability to provide our patients with access to the most current technology. We seek to maximize immediate and long-term benefits of quality care to the patient and to society. We seek to regain public confidence in this era of medical consumerism and cost consciousness. It is with renewed public confidence and respect that we can hope to maintain public support for our concerns in important areas facing our profession. We seek to maintain a unifying response in a fragmented world.

The breadth and diversity of medicine is at once our strength and our weakness. Medicine represents at this time a broad range of interests. We are vulnerable because of this as well. We must not divide our energies and resources at a time when we need a strong voice in health policy matters, a cooperative coordinated approach to continuing medical education, and a critical assessment of our future pathways. Our credibility as a profession and our effectiveness in achieving solutions to today's complex health care depends on the success of our working together.

The Medical Society of New Jersey seeks leadership which will allow it to act effectively in addressing health policy issues, foster unity in the medical community, and maintain its role as a leader in education. Development of sound programs to the challenges facing medicine should be our primary focus.

It is with an understanding of the complexity of these issues, and the need for a knowledgeable individual experienced in both leadership and the delivery of compassionate and skilled medical care, that I present to you, Dr. Paul Hirsch, your next president. □ Stuart A. Hirsch, MD

Dr. Formica, Mr. Speaker, officers and trustees of the Medical Society of New Jersey, members of the House of Delegates, and guests: It is a pleasure and a privilege for me

Dr. Hirsch is the 197th president of MSNJ; he presented this speech on Friday, April 28, 1989, at the 223rd Annual Meeting of the Medical Society of New Jersey.

to speak to you at this Annual Meeting of the oldest medical society in the nation. Our Society now is 223 years old and I am as confident of our future, as I am proud of our past. I am confident and optimistic because we represent the physicians of this state, in their determination to advance, to protect, and to defend the availability of quality medical care for our patients. That is what we stand for; that is why

INAUGURAL ADDRESS

we have been successful, and that is why we must be successful.

Our continued success will depend upon our ability to identify and to meet the challenges of the future, for many of those challenges will represent opportunities, if we are but able to respond effectively.

I would like to speak with you about some of the challenges and some of the opportunities now before us, and some of the priorities of your Medical Society.

Continued membership growth has been emphasized by every recent president of this Society. We already represent the vast majority of practicing physicians in New Jersey. If we are to be effective in meeting our challenges, we must continue to represent a majority; we must continue to encourage young physicians to join us, and senior physicians to maintain their active status within our ranks at the Society.

I firmly believe our membership goals are best achieved by enhancing our programs, by increasing communication with our members, by increasing opportunities for participation in the activities and leadership of the Medical Society of New Jersey, and by continuing to represent the best interests of our patients.

Fragmentation of our profession is the enemy of membership growth, and the enemy of success in our efforts. We must be united. The appropriate organization for unity of the medical profession in this state, is the Medical Society of New Jersey.

If we are to unify, if we are to avoid fragmentation, we must not be afraid to broaden our ranks. We must not be afraid to give meaningful participation in our organization, in our deliberations, and in our decision making, to our specialty societies and other medical groups. We must simultaneously work to strengthen our 21 county medical societies, which are the very heart and soul of our state medical society.

A number of years ago, we changed our constitution and our charter to permit representation from the specialty societies in our House of Delegates. Some predicted dire consequences, but there have been none. Nevertheless, this was but one very small step.

I intend to take additional specific steps to increase participation by our members who are active in other medical groups and organizations, and to increase their involvement in our Medical Society—their medical society. I hope that these steps, like the small step of representation in the House of Delegates, will lead to larger steps in the future. The Medical Society of New Jersey is and shall be the organization for effective medical unity in this state.

Leadership development is a vital challenge. It is crucial to the growth of membership and to the success of our organization. Leadership is not a reward; it is an obligation of those able to provide it. Leadership does not offer privilege; it demands responsibility. It demands hard work. Those in leadership positions must actively support our efforts, support our goals, and support the Medical Society of New Jersey.

We have a great deal of leadership available, we have an abundance of talent available, if we but provide the opportunity.

In order to provide greater opportunity, the new Committee on Appointments has been charged with broadening the appointment process, expanding the opportunities for leadership, and using to full advantage the talents available in our membership. The actions of this Committee already have resulted in new opportunities for committee chairmanships and vice-chairmanships, and for committee appointments. I believe that this Committee will have an increasing effect in providing leadership opportunities, in the future.

I also am appointing a Task Force on Leadership, to identify, encourage, and develop leadership abilities. As a demonstration of the importance that I assign to this task, I am appointing Dr. Palma Formica, to head this Task Force.

Strategic planning is a most important challenge for a large successful organization. We must look carefully and critically at ourselves, to see where we have been, and where we should be going, to prepare ourselves to anticipate and meet the challenges and opportunities of the future.

I have directed our Committee on Long-Range Planning and Development to begin promptly a thorough and wide-ranging process of evaluation and planning. This Committee will have maximum staff support. Their written report will form the basis of a Board of Trustees workshop on long-range and strategic planning, before the next Annual Meeting. I will report to you about our progress, next year at this time.

Communication—clear and frequent communication—is a challenge for individuals, for nations, and for medical societies. Communication between the Society and the membership is crucial. Communication in both directions is a key to understanding the needs of membership, to increasing participation, and to implementing our policies.

We have made increasing use of our outstanding journal in communicating with our membership. Specific areas of information are contained in the MSNJ Newsletter, the Capitol Commentary regarding legislative activities, the Professional Liability Commentary, and the President's Page, all of which

INAUGURAL ADDRESS

now regularly appear in *NEW JERSEY MEDICINE*. The President's Hotline is sent separately, and additional bulletins have been sent as needed and when appropriate.

We recognize our obligation to communicate with you and to provide information about the issues that are important to you. We will continue to increase the flow of information to you: in the journal, in your mail, through your county medical society, and on your hospital bulletin board. Look for us; we'll be there.

Sound financial planning is necessary to the success of all of our programs. This has been a particular interest of mine, since my years as treasurer. In order to secure financial stability, we have sought and developed income from non-dues sources, and have monitored expenses carefully. Because of this, we will be able to expand our programs this year; and for the second successive year, we have recommended no dues increase.

We will continue to work for increased services, without increased dues.

Until a few years ago, a discussion of the obligations and activities of a state medical society could have ended with a discussion of membership activities. The obligation of public service was best accomplished by the individual physician. This no longer is so. The structure of government and community has become so complex that our membership and our patients require that this organization provides service to our citizens, including public education regarding health care.

Education about health, and about our profession, is accomplished through our program of public relations, or perhaps we should call it a program of public education, for that is what it is. This program is the envy of other state medical societies, and indeed it has received the supreme accolade of imitation. I know that you care about this program, and I care about this program. It increasingly will assist us in reaching out to our patients, and talking to them.

We are all accustomed to changes in medicine, and changes in the way that we practice, arising from many sources: basic laboratory research, clinical investigation, and serendipitous discoveries.

More recently, the most profound changes affecting our practice, and the health of our patients, have not originated in laboratories, or in our hospitals. The most profound changes have originated with government, with health policy, and with related public policy. This, I believe, has presented us with the greatest challenge of all.

Government at all levels, through the legislative and regulatory processes, increasingly impacts upon the way we practice, and upon the quality of care

delivered to our patients. The resultant policies sometimes neither are logical, nor rational, nor fair; they nevertheless, are law. Physicians feel frustrated, hopeless, and helpless. The situation is frustrating, but it is not hopeless, and we are not helpless.

We can participate in the formation of legislation and regulation through the political process. Politics is not a dirty word; it is the name that we give to the democratic system.

Why should we participate? Why should we care about government? Because so much of what we do care about, will be determined by this process. We must participate, because we care.

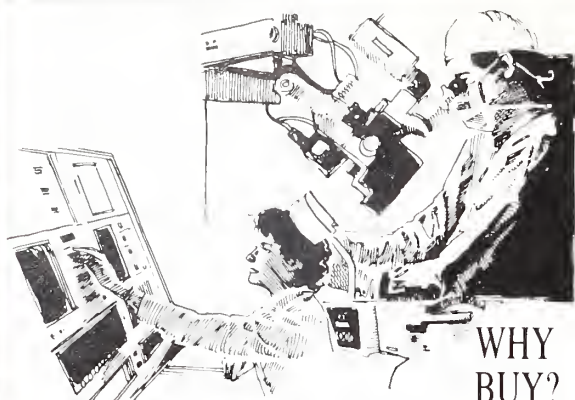
Because we care about our patients. Because we care about AIDS and the devastation it is causing and will cause. Because we care about the effects of drugs on our youth, on our community, on the very structure of life in this country. Because we care about a measles epidemic. Because we care about the desperate shortage of nurses and other health personnel. Because we care about our fragile environment. Because we care about safe medical waste disposal. Because we care about the cost of medical care, and even more about the quality of medical care. Because we care about access to quality care for our senior citizens, and for all citizens. Because we care about the quality of life of the citizens of New Jersey. Because we care.

Because we care. That is why we must be involved with government, with legislation, with regulation, and with politics: because we care. And because we owe it to our patients to participate on their behalf.

We recognize our obligation to educate our public leaders with regard to medicine and health. We will increasingly bring the benefit of our experience and our knowledge to health policy regulation and legislation.

This year, we will add to our efforts, a legislative workshop, involving members of our Legislature, members of the Board of Trustees, and other members of the Medical Society of New Jersey. Other new programs are under consideration. We will meet this challenge; we will participate in the formation of public policy affecting the health and quality of life of our patients.

These are some of our priorities—health policy, public policy, public education, communication, strategic planning, leadership, membership, and unity; these are but some of the challenges (and opportunities) we face. We, the medical profession; we, the Medical Society of New Jersey; we, you and I. And I challenge you, each of you, to join with me in facing the future and in making it a better future for medicine, a better future for our patients, a better future for the citizens of New Jersey. ■



WHY
BUY?

WE PROVE IT COSTS LESS TO LEASE!

Medical & Office Equipment Leasing
We Are The Experts!
Call For Information

HTFS

Contractors for
Metro West and
Metro Essex Home Care

HI-TEC FINANCIAL SERVICES

2191 MILLBURN AVE. • MAPLEWOOD, NJ
(201) 763-3256

TURN TO THE
PROBLEMS?
EXPERT
FOR ADVICE

MARY ANN
HAMBURGER
ASSOCIATES



• SELECTING THE BEST OFFICE LOCATION IS A CRITICAL DECISION IN LAUNCHING A NEW PRIVATE PRACTICE. MARY ANN BRINGS MANY YEARS' EXPERIENCE IN MEDICAL OFFICE MANAGEMENT TO THAT DECISION

• AFFILIATING WITH THE RIGHT HOSPITAL(S) IS ESSENTIAL TO THE SUCCESS OF A NEW PRACTICE. MARY ANN HAMBURGER'S CONTACTS WITH HOSPITAL ADMINISTRATORS—HER KNOWLEDGE OF THEIR NEEDS AND YOUR SPECIALTY—CAN SMOOTH THE WAY TO A MUTUALLY REWARDING RELATIONSHIP

• DEVELOPING AN EFFICIENT, CARING OFFICE ENVIRONMENT IS THE FOUNDATION OF A SOUND OFFICE PRACTICE. MARY ANN IS AN EXPERT IN EVERY DETAIL OF OFFICE ADMINISTRATIONS, FROM PHONE SYSTEMS AND BILLING TO FINANCES, FURNISHINGS AND PERSONNEL.

FOR A WHOLE NEW APPROACH TO YOUR OFFICE PRACTICE, CONTACT:

MARY ANN HAMBURGER ASSOCIATES

74 HUDSON AVENUE • MAPLEWOOD, NJ 07040

201 763-7394

PHYSICIANS KNOW HOW IMPORTANT
QUALITY HEALTH CARE INSURANCE IS...

THAT'S WHY MORE N.J. PHYSICIANS CHOOSE
MSNJ GROUP HEALTH CARE PLANS THAN
ALL OTHER POLICIES COMBINED.



MSNJ GROUP

BLUE CROSS/BLUE SHIELD
AND MAJOR MEDICAL INSURANCE

DENTAL INSURANCE

LONG-TERM CARE INSURANCE

For more information, call (609) 924-8700

DONALD F. SMITH & ASSOCIATES

Presidential Address

PALMA E. FORMICA, MD

As this 222nd year of the Medical Society of New Jersey ends, it is time for me, your outgoing president, to render an accounting of my term of office. I shall not repeat the accomplishments and failures or the hits and the misses of this year. They are in the Annual Report.

I want to take this time to say my thanks to Drs. Paul Hirsch and Harry Carnes. They were my book-ends, not only providing me with support and strength, but also keeping me straight.

My gratitude also goes to our executive director, Vincent Maressa and his staff, without whose help the business of this organization would not have been accomplished so effectively and diligently.

I am appreciative of the considered deliberations of the Board of Trustees, the advice of the executive committee, and the chairmen of the councils and committees and their members, and the officers and executives of the county societies.

But, most specifically to you, the delegates of this house and the members you represent, I say, thank you. You have given me a singular honor—a very good year.

Dr. Formica presented this address at the 223rd Annual Meeting of the Medical Society of New Jersey, held at the Sheraton Meadowlands Hotel in East Rutherford. Correspondence may be addressed to Dr. Formica, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

I am proud to have been your president.

I had hoped to emulate Dr. John Madara, who holds the record of being the most travelled president—indeed the consummate ambassador of good will. I tried to visit every county as he did, but I did not quite make it. I tried to go everywhere I was invited, but not every county extended an invitation in time for me to work a visit into my schedule.

The year has gone by so quickly. I leave with ambivalence, but other heads and hands will find the solution to the Gordian knots facing medicine.

I believe we have done much, not always what and how everyone wanted, but we acted.

I believe we represented you.

Now is not the time for one physician to be pitted against another, that is what the regulators would have us do—be divided.

So we can be picked off, one at a time.

Unity must be our byword. Together, there is no problem we cannot solve if we stand unified.

We cannot afford to be silent and apathetic—licking our wounds and bemoaning our fate.

We can be walked on, only if we, as physicians, are lying down.

And, finally, let us all remember we are physicians. Patients are the reason for our being! First and foremost, is our dedication to them.

All other good things will follow if we are true to our commitment. ■



Dosing Flexibility

Android[®] / 5^{Buccal} / 10^{Oral} / 25^{Oral}
mg mg mg

Methyltestosterone U.S.P. Tablets

Android[®] / F

Fluoxymesterone U.S.P. Tablets, 10 mg.

BROWN BROWN PHARMACEUTICAL COMPANY, INC. 3300 Hyland Avenue, Costa Mesa, CA 92626



For Full Prescribing
Information
Please See PDF

Steroid Use in Asthmatics

MARC ADELMAN, MD
BENJAMIN H. SAFIRSTEIN, MD

Patients with steroid-dependent asthma were evaluated for possible complications of long-term steroid administration. The frequency of these complications was related to dose and duration of therapy.

The incidence of significant complications following the chronic use of corticosteroids continues to be controversial. Smyllie reported that hypertension, osteoporosis, obesity, and ulcers occurred with no greater frequency in steroid-treated asthmatics than in the control group of asthmatics not treated with steroids.¹ Adinoff, however, found vertebral fractures in almost 40 percent of steroid-treated asthmatics² and Kwong found an incidence of cataracts in 28 percent of steroid-treated asthmatics.³ Lieberman reported weight gain, fluid retention, hypertension, and diabetes mellitus in asthmatics taking corticosteroids regularly for asthma.⁴ The side effects for these pa-

tients, however, were felt to be clinically benign and easily managed.

The purpose of this study was to determine the incidence of clinical complications in patients with asthma treated with high- and low-dose steroids. It is our purpose to define those factors that increase the incidence of severe side effects.

MATERIALS AND METHODS

Fifty-four patients with steroid-dependent asthma for at least one year attending Saint Michael's Medical Center, Newark, were studied. In addition, all patients were being treated with albuterol or salbuterol. Twelve of the patients were using theophylline preparations. Asthma was defined as reversible airway obstruction with at least 15 percent change in FEV₁ by spirometry. All patients with chronic nonreversible airway obstruction were excluded. All patients were evaluated initially with a comprehensive history and physical examination,

Drs. Adelman and Safirstein are affiliated with the Department of Pulmonary Medicine, Saint Michael's Medical Center. Requests for reprints may be addressed to Dr. Adelman, Saint Michael's Medical Center, 268 Martin Luther King Jr. Blvd., Newark, NJ 07102.

complete blood count (CBC), electrolytes, SMA 12, postprandial blood sugar, and PPD. Chest x-rays were performed on all patients. Weight and blood pressure were recorded on each visit. During follow-up, symptoms of gastrointestinal (GI) distress were noted. An upper gastrointestinal series was performed in all symptomatic cases, as well as 8 patients who were asymptomatic. At the termination of the study, all 54 patients underwent complete reevaluation, including CBC, fasting blood sugar, and electrolyte examination. Ophthalmologic evaluation for cataract determination was undertaken, as well as radiologic examination of the chest and lumbosacral spine. A rapid screening test of adrenal function described by Wood and associates was performed.⁵

Corticosteroids were administered orally as prednisone, and levels were maintained at the smallest dose that would prevent disabling symptoms. Patients were divided into two groups by their average daily dose—low-dose and high-dose prednisone. The low-dose group consisted of 27 patients taking less than 15 mg/day of prednisone, and the high-dose group consisted of 27 patients taking greater than 15 mg/day of prednisone. We also divided our patient group by age: under 50 years of age (32 patients), and over 50 years of age (22 patients); and by duration of therapy: using prednisone for one to three years (15 patients), and using prednisone for more than three years (39 patients).

RESULTS

There were 40 female patients and 14 male patients. The average patient age was 47 years old.

Cushingoid Signs. Cushingoid signs were common. Acne was noted in 3 patients; although this type usually is not associated with steroid use. We noted striae in 5 patients, hirsutism in 8 patients, and moon facies in 20 patients. Other patients revealed easy bruisability. Cushingoid signs were more common in females. Hirsutism occurred only in patients between the ages of 30 years and 50 years who had been using steroids for greater than 7 years, and who had been taking steroids for greater than 15 mg per day.

Weight Gain. Weight gain of more than five pounds was noted in 30 patients (56 percent), occurring predominantly in the first year. Of the patients who gained more than five pounds in the first year, there were 19 patients (70 percent) in the high-dose group and 11 patients (41 percent) in the low-dose group and 20 patients (63 percent) in the younger age group, and 10 patients (45 percent) in the older age group.

Hypertension. Diastolic pressure greater than 90 mmHg occurred in 18 patients (33 percent) in our study, and the diastolic pressure never rose above 105 mmHg. Twelve patients were female and 6 patients were male. Hypertension occurred generally in the first year of use in the high-dose group. Age of

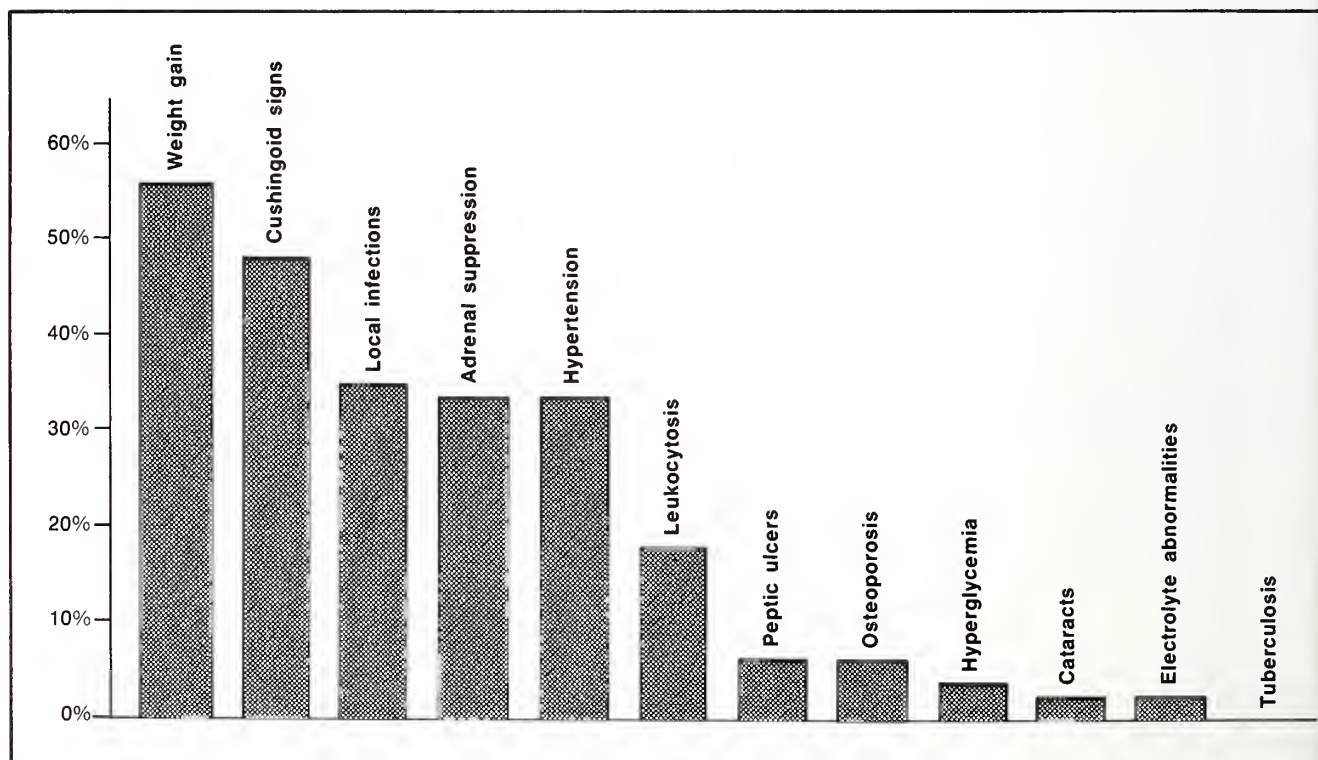


Figure 1. Incidence of complications in steroid-dependent asthmatics.

the patient and duration of therapy was of no significance. In two patients, thiazides were provided to control blood pressure; all other patients responded to salt restriction or reduction in dose. There was no morbidity associated with stroke, heart disease, or renal insufficiency.

Infections. Vaginal yeast infections were seen in ten patients during the study period. In all cases, the yeast infections were treated topically. Vaginitis occurred in both high- and low-dose steroid groups and was not related to age, dose, or duration of therapy. Community-acquired pneumonias were documented in six patients. All infections were treated effectively. There was no relation to dose or duration of steroid use.

No opportunistic infections were seen. Urinary tract infections were documented in three patients. All responded to antibiotics. No episodes of tuberculosis were documented in any steroid-treated patient. Twenty-three patients had positive tuberculin skin tests prior to treatment with steroid therapy and none were treated with isoniazid (INH) prophylactically.

Electrolytes. We could find no evidence of abnormal sodium metabolism. One patient demonstrated an elevated serum chloride and low serum

potassium. This patient was treated with potassium chloride supplementation.

Blood Sugar. Only two patients (4 percent) demonstrated development of abnormal two-hour postprandial blood glucose determinations. Both patients were males over 50 years of age; in each instance, hyperglycemia occurred in the first year of oral steroid use. There was no evidence of glycosuria and each patient was controlled with dietary modification.

Gastrointestinal. Clinical symptoms of heartburn relieved by antacid were reported in 11 patients; all underwent radiographic evaluation of the stomach and duodenum. Three male patients who had been on 15 mg prednisone daily demonstrated radiographic evidence of duodenal ulcers. All radiographic evaluations looking for asymptomatic ulcers were negative.

Ophthalmologic. Among 33 patients who underwent slit-lamp eye examinations, only one patient had a cataract; the patient was over 50 years old and had been on oral prednisone for 12 years. The cataract was anterior in location. No evidence of elevated intraocular pressure could be demonstrated in any group of steroid-treated patients.

Osteoporosis. Lumbosacral spine radiographs

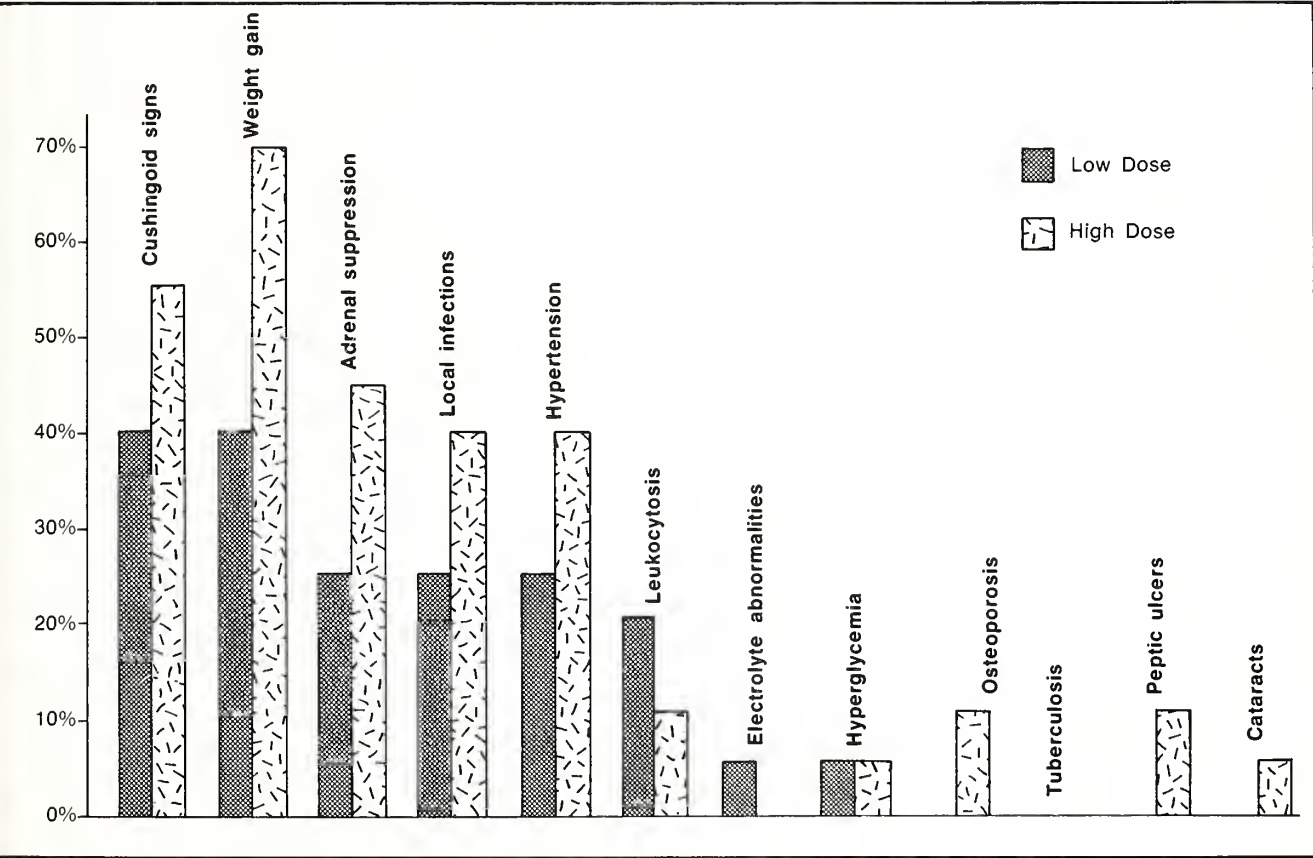


Figure 2. Comparison of incidence of complications in low- and high-dose steroid-treated groups.

were obtained in 37 patients. Three patients, all female and over 50 years old, showed evidence of bony demineralization compatible with osteoporosis; all three patients had a history of low-back syndrome and had been maintained on 15 mg/day of prednisone. Fifty-four patients underwent radiographic evaluation of the chest. No instances of rib fractures were documented. Demineralization of the lateral aspects of the clavicle was not documented and vertebral collapse did not occur in any patient. Aseptic necrosis of the femoral head was not seen.

Adrenal Function. Forty-two patients underwent a Cortrosyn™ stimulation test. Six patients had tests that were considered nondiagnostic. Of the 36 tests that were considered diagnostic, 18 patients (50 percent) showed adrenal suppression. The patients were divided equally among high- and low-dose groups, younger and older age groups, and all durations of therapy. Steroid withdrawal syndrome occurred occasionally and was managed with slower tapering.⁶ Hypotensive episodes compatible with pituitary insufficiency or adrenal collapse were not seen.

DISCUSSION

Our data revealed the incidence of serious complications of chronic steroid use (uncontrolled hypertension, peptic ulcer disease, cataracts, osteoporosis, and opportunistic infections) was small. Less serious

complications such as weight gain, cushingoid symptoms, and yeast infections were seen frequently. Weight gain was seen in the majority of patients. Vaginal yeast infections were common but were managed easily. Cushingoid signs, occurring in the high-dose group and in those patients using prednisone for more than three years, were noted. Of our more serious complications, hypertension was seen frequently—in 18 patients (33 percent).

Our study was in agreement with Smyllie who found that hypertension complicating corticosteroids was relatively benign as reflected in the absence of mortality.¹ Lieberman did not find any instances of renal insufficiency or myocardial failure, which matched our studies.⁴ McAllen found hypertension in 8 percent, which is significantly lower than in our group.⁷ There was no mention of the standards used to define hypertension. Tuft also found a low incidence of hypertension.⁸ This might be explained by the lower maintenance dose used in his group. The patients that developed hypertension in our study tended to be in the high-dose group (41 versus 26 percent).

We had only three cases of peptic ulcer disease; this is in agreement with many other studies.^{1,4,7-10} The development of peptic ulcer disease occurred in patients who were taking more than 20 mg/day of prednisone, and it occurred within the first year of

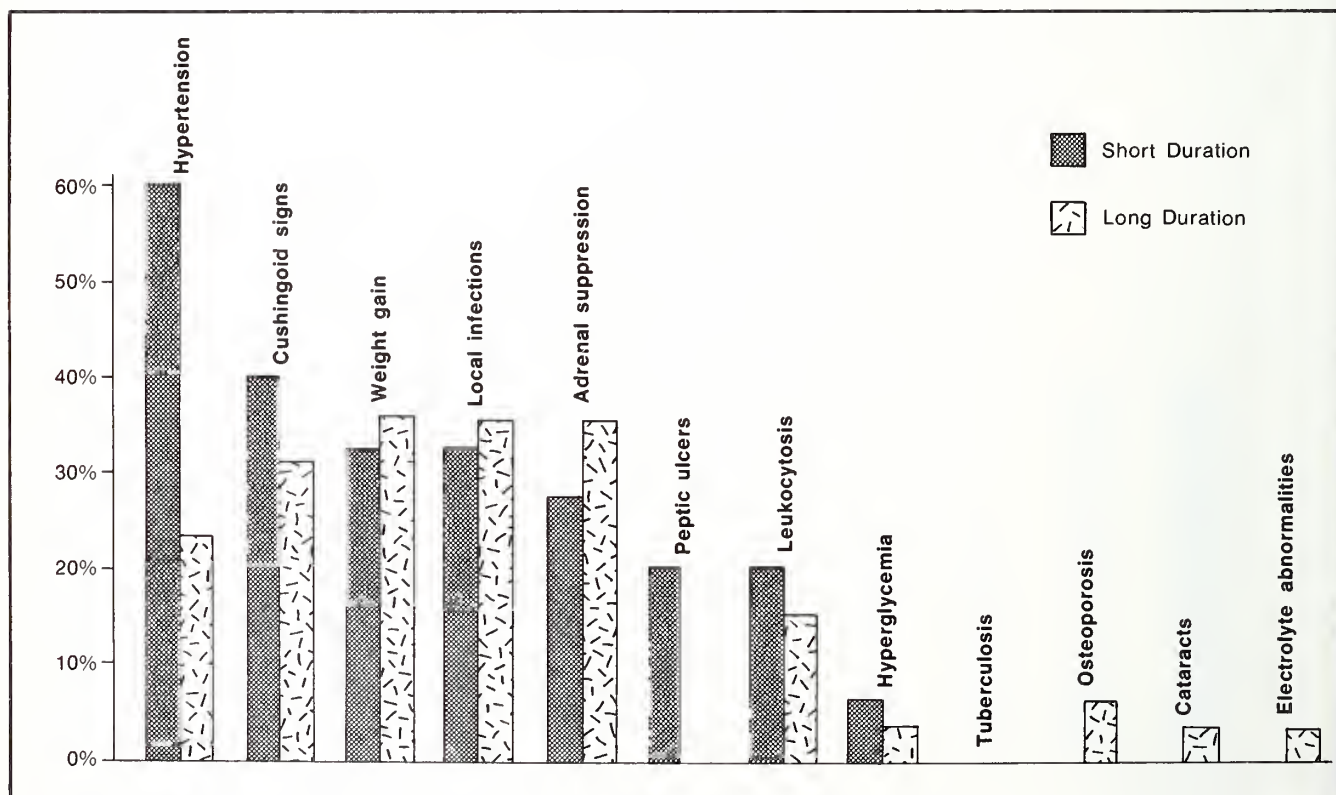


Figure 3. Comparison of incidence of complications between short and long duration of therapy in steroid-treated groups.

use. The ulcers were duodenal in nature and uncomplicated, and responded to medical therapy. (We make no statement as to cause and effect.)

Posterior subcapsular cataracts (PSC) have been reported to occur with systemic corticosteroid therapy.^{8,11,12} Our data revealed no evidence of PSC and only one case of an anterior cataracts. Our low incidence of cataracts is in agreement with other studies.^{1,4,7} Most of the cases of PSC reported were in patients with rheumatoid arthritis who were taking high-dose steroids. Giles reported a series of 12 asthmatic patients taking moderate doses of corticosteroids that revealed 2 patients with PSC.¹¹ Kwong found an incidence of PSC of 28 percent.³ In this group, the mean age was 59 years old, with only 6 patients younger than 50 years old. They also may have been taking higher doses for a longer duration. It is our opinion that PSC occurs rarely in younger asthmatics using doses of prednisone of less than 15 mg/day.

Our studies failed to confirm the findings of Adinoff who reported a high incidence of rib and vertebral fracture among steroid-treated asthmatics.² Our study was designed to study radiologic evidence of osteoporosis and did not measure bone density. Of 54 patients, only 3 patients (5.8 percent) had clinical and radiologic evidence of bone resorp-

tion. None of the 3 patients, however, had rib fractures. Three of our patients received 15 mg/day of prednisone for greater than seven years, and were over the age of 50. We could find no evidence of bone loss in any patient receiving 10 mg/day. Our study was in agreement with the findings of Mueller who found no changes in bone mineral content in steroid-treated asthmatics.¹³ The rate of vertebral collapse reported by McAllen was 3 percent of steroid-treated asthmatics, which is similar to our finding of 5.8 percent.⁷ In McAllen's study, all but 2 patients were over 60 years of age, and all were maintained on greater than 20 mg/day of prednisone. McAllen found no vertebral collapse in low-dose regimens. Reports by Tuft⁸ and Lieberman⁴ also found a low incidence of osteoporosis in the steroid-treated group. The significant difference in the incidence of osteoporosis reported by Adinoff and other larger series is difficult to explain.²

Our group of patients were similar in age, sex, and duration of steroid therapy to those in other reported series. One major difference may be the steroid dosage. Adinoff's group consisted of referred asthmatics who may have received large doses of steroids prior to their care at National Jewish Hospital. Our clinical osteoporotic complications occurred at a higher dose setting.

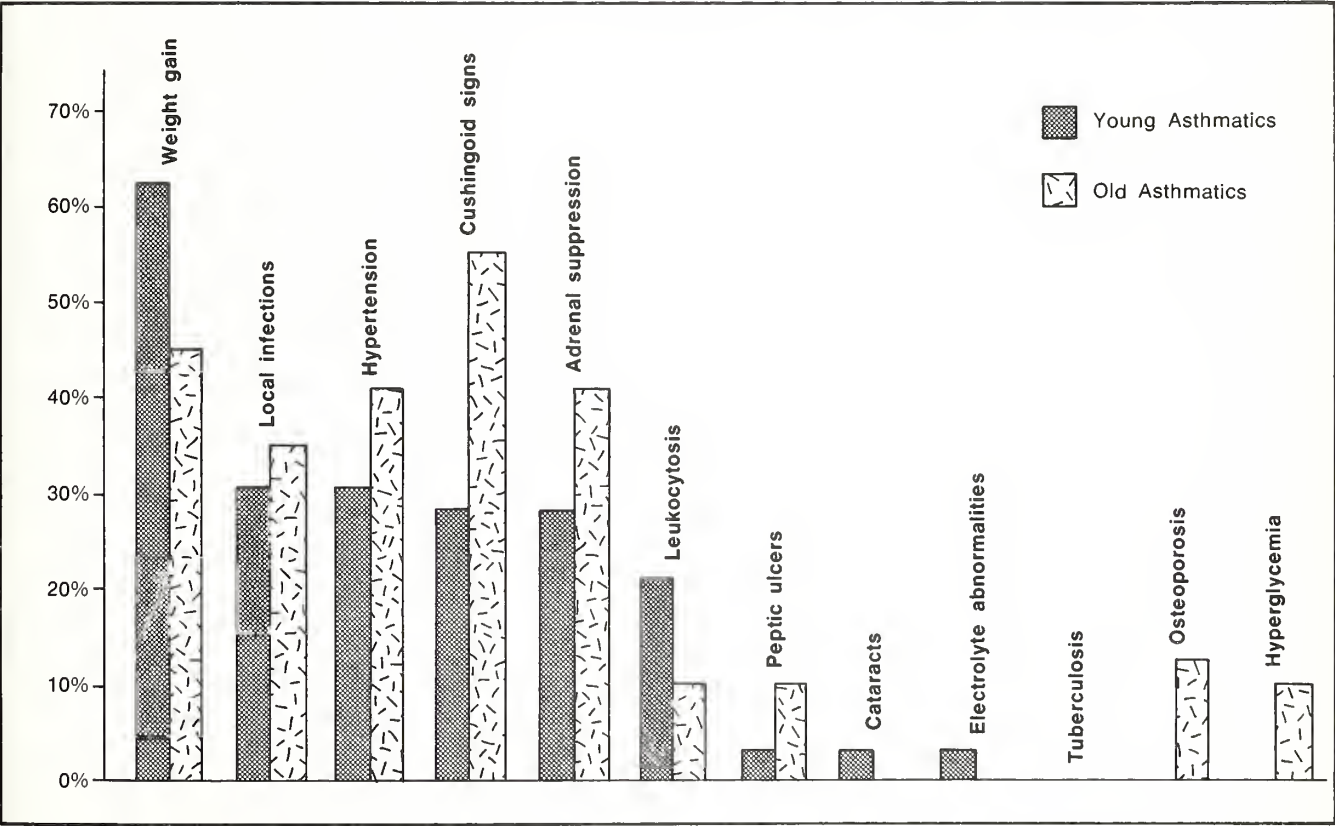


Figure 4. Comparison of incidence of complications between young and old age groups in steroid-treated asthmatics.

Our incidence of glucose intolerance was low (two cases), which is in agreement with other studies.^{1,7,8} Lieberman found an incidence of 28 percent with a positive correlation with age and increasing dose.⁴ We can find no explanation for his high percentage of glucose intolerance as compared to our own. Both of our patients were males. Curiously, Smyllie noted that eight of nine corticosteroid diabetics were males.¹ Our patients were managed only with diet. There were no episodes of acidosis.

Bayshawe has shown that administration of hydrocortisone in high doses causes a fall in plasma-potassium.¹⁴ We observed one case of hypokalemia and no alterations of sodium metabolism. Other studies have shown incidences of hypokalemia ranging between 10 and 18 percent.^{4,7} No ranges are given in these studies. Our present patient has been maintained on oral supplements without complications.

Sawyer presented three patients with hypokalemia who received large doses of hydrocortisone. We could not find documentation of hypernatremia by any other investigator when corticosteroids were administered in doses below 30 mm/day of prednisone.

Our data dramatically support the contention that exogenous steroid therapy suppresses adrenal steroid secretion.^{3,16,17} We observed 18 cases (33 percent) with an abnormal CortrosynTM stimulation test as defined by Wood.⁵ We did not have any episodes of adrenal collapse.^{1,7} Although it is clear that

adrenal suppression occurs, Melby has shown that adrenal response to stress is variable and may recover earlier than some adrenal stimulation tests show.¹⁹ In our patients, we administered methyl prednisolone intravenously during all acute events, including surgical procedures.

We did not have any reactivation tuberculosis in our study group, not even in the 23 patients with positive tuberculin skin tests. Others, including Sahn have reported episodes of reactivation of tuberculosis after corticosteroid administration.¹⁷ In most cases, a disease-impairing host defense was present and many were taking additional immunosuppressants. Schatz found no evidence of active tuberculosis in 132 corticosteroid-treated asthmatics and recommended against INH prophylaxis. We are in agreement with this conclusion.¹⁸ Opportunistic infections were not seen and there were low incidences of other common infections.

CONCLUSION

Corticosteroid complications in asthmatic patients generally are benign. Peptic ulcer disease, osteoporosis, and cataracts are seen infrequently and only in patients taking higher daily doses. Other side effects that commonly are seen (hypertension and adrenal suppression) may be managed with little morbidity. Steroid-dependent asthmatics can be managed safely, with minor complications. ■

REFERENCES

1. Smyllie HC, Connolly CK: Incidence of serious complications of corticosteroid therapy in respiratory disease. *Thorax* 23:571-581, 1968.
2. Adinoff AD, Hollister RJ: Steroid-induced fractures and bone loss in patients with asthma. *N Engl J Med* 309:265-268, 1983.
3. Kwong FK, Sue MA, Klaustermeyer WB: Corticosteroid complications in respiratory disease. *Ann Allergy* 58:326-330, 1987.
4. Lieberman P, Patterson R, Kunske R: Complications of long-term steroid therapy for asthma. *J Allergy Clin Immunol* 49:329-336, 1971.
5. Wood JB: A rapid test of adrenocortical function. *Lancet* 1:243, 1965.
6. Dixon RB, Chrispy NP: On the various forms of corticosteroid withdrawal syndrome. *Am J Med* 68:224-230, 1980.
7. McAllen M: Long-term side effects of corticosteroids. *Respiration* 27:250-259, 1970.
8. Tuft L: Steroid-phobia in asthma management. *Ann Allergy* 42:152-159, 1979.
9. Conn HO, Blitzer BL: Nonassociation of adrenocorticosteroid therapy and peptic ulcer. *N Engl J Med* 294:473-478, 1974.
10. Cooke AR: Corticosteroids and peptic ulcer: Is there a relationship? *Am J Digest Dis* 12:323-329, 1967.
11. Giles CL, Mason GL, Duff IF, McLean JA: The association of cataract formation and systemic corticosteroid therapy. *JAMA* 182:139-142, 1962.
12. Black RL, Oglesby RB, Sallamann LV, Bunim JJ: Posterior subcapsular cataracts induced by corticosteroids in patients with rheumatoid arthritis. *JAMA* 174:150-155, 1960.
13. Mueller MN: Effects of corticosteroids on bone mineral in rheumatoid arthritis and asthma. *AJR* 126:1300, 1976.
14. Bayshawe KD, Curtis JR, Garnett ES: Effect of prolonged hydrocortisone administration on potassium metabolism. *Lancet* 1:18-21, 1965.
15. Sawyer RB, Spencer JR, Dudzinski PJ, Enis JE: Hypernatremia with pharmacologic doses of steroids. *Am J Surg* 114:691-694, 1967.
16. Meakin WJ, Tantonglo MS, Crabbe J, et al.: Pituitary-adrenal function following long-term steroid therapy. *Am J Med* 30:459-464, 1960.
17. Sahn SA, Lakshminarayan S: Tuberculosis after corticosteroid therapy. *Br J Dis Chest* 70:195-205, 1976.
18. Schatz M, Patterson R: The prevalence of tuberculosis and positive tuberculin skin tests in a steroid-treated asthmatic population. *Ann Intern Med* 84:261-265, 1976.
19. Melby J: Systemic corticosteroid therapy: Pharmacology and endocrinologic considerations. *Ann Intern Med* 81:505-512, 1974.

Pyoderma Gangrenosum

JEFFERY W. SEITZINGER, MD

Pyoderma gangrenosum is an unusual ulcerative dermatitis of unknown etiology; it is associated with systemic disease. This case report and discussion of the literature detail the recognition of pyoderma gangrenosum, the importance of both local care and treatment of systemic illness, and the current therapeutic options available.

P pyoderma gangrenosum is an unusual ulcerative dermatitis of unknown etiology, frequently associated with systemic disease. Recognition of the disease is based on the distinctive appearance of the lesions, the association with systemic disease, and the exclusion of other causes of dermatitis. Therapy remains symptomatic, along with control of any systemic disease.

CASE REPORT

A 69-year-old white female, with a history of documented Crohn's colitis, underwent a segmental colon resection in 1983. Also, the patient suffered from pyoderma gangrenosum involving her lower extremities, requiring split thickness skin grafting in the same year. The patient returned with acute exacerbation of both her inflammatory bowel disease

and pyoderma gangrenosum of her left leg and hand.

She was admitted with five to six loose bowel movements per day, abdominal pain, anorexia, weakness, and painful extremity ulcers. The patient initially was placed on intravenous steroids, Flagyl®, Ancef®, and hyperalimentation. Local wound care was given. There was minimal improvement in her condition and Imuran® was added to her therapeutic regimen. Subsequently, her bowel function improved and she tolerated a regular diet. Her extremity wounds healed slowly with local care only and she was discharged in good condition.

DISCUSSION

An idiopathic ulcerative skin disease with characteristic lesions consisting of irregular, boggy, blue-red, and undermined borders surrounding a necrotic base first was described as pyoderma gangrenosum by Brunsting in 1930. In their classic form, the ulcerations are diagnostic. The original description of Brunsting, Goeckerman, and O'Leary still is applicable:

Dr. Seitzinger is affiliated with Saint Barnabas Medical Center, Livingston. Requests for reprints may be addressed to Dr. Seitzinger, 141 Old Short Hills Road, Apt. 84, West Orange, NJ 07052.

The borders of the ulcers were well defined because of their striking blue color, which clearly outlined the lesion as it extended peripherally in rough serpiginous configuration. The blue zone consisted of an edematous, boggy strip from 5 to 8 cm wide in which there had been extensive undermining and necrosis of the subcutaneous tissue, the epidermis remaining as a thin, gray, translucent film extending over the crater of the lesion, in a ragged, irregular fashion. On the advance of the undermining process, often at the rate of 1 to 2 cm in 24 hours, a zone of erythema extended as an areola into the area of normal skin.

The base was moist and covered with mucopurulent exudate of pus and tissue debris, which exuded from the area of necrosis. Pressure on the border caused considerable gelatinous pus to ooze into the wound.

Healing occurred by epithelial outgrowths from the periphery, with resulting thin, atrophic scarring, with some brownish pig-

mentation. After healing, the scars maintained the serpiginous outline.¹

Originally, because of culturing of *Staphylococci* and hemolytic *Streptococci*, the disease was thought to be infectious. However, the cause remains unknown. It frequently is associated with local trauma or the application of iodides as well as the exacerbation of systemic disease.² Several theories have been proposed: Thorton suggests pyoderma may result from an immunologic reaction to bacterial or dietary antigens absorbed through damaged mucosa.³ Greenberg correlates the disease with depressed lymphocyte inhibitory factor.⁴ Powell described a monoclonal gammopathy in pyoderma.⁵

Clinically, females are affected more often than males by almost a two to one ratio. All age groups have been affected. The lesions usually are multiple and exquisitely tender; they exhibit a preference for the lower extremities. These lesions generally appear during the course of active bowel disease and frequently occur with exacerbation of colitis.⁶

The majority of patients with pyoderma gangrenosum have an associated illness. Chronic ulcerative colitis is seen in approximately 50 percent of all cases. However, pyoderma gangrenosum occurs



Figure 1. Pyoderma gangrenosum of the ankle.

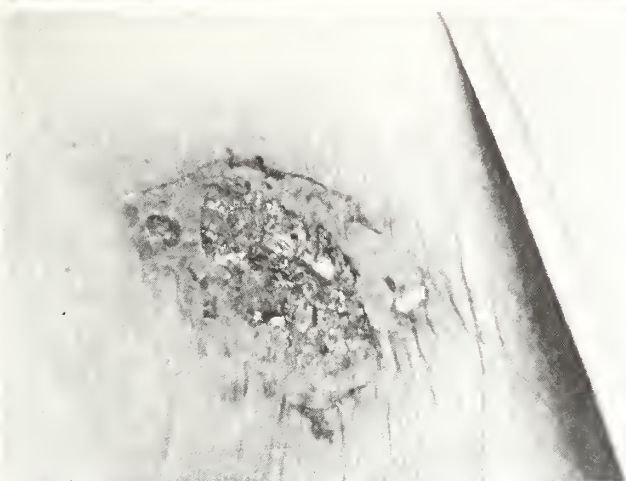


Figure 2. Pyoderma gangrenosum of the medial thigh. Note the serpiginous outline and undermined border.

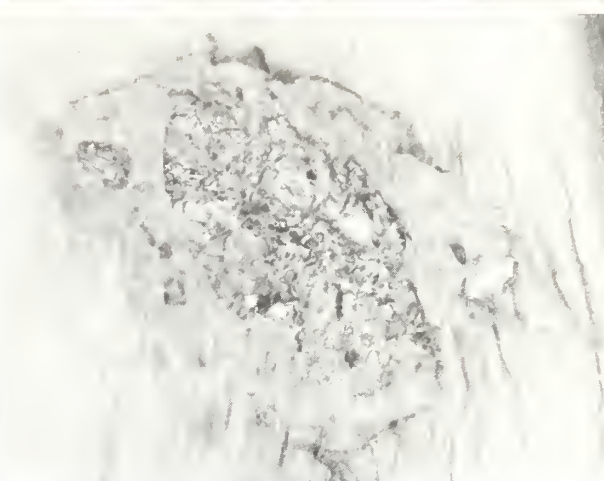


Figure 3. A closeup of Figure 2; pyoderma gangrenosum of the medial thigh.

in less than 5 percent of patients with ulcerative colitis.⁷ Other diseases associated with pyoderma gangrenosum include chronic active hepatitis, diverticulitis, diverticulosis, and Crohn's disease. Rheumatoid arthritis, myeloid metaplasia, polycythemia vera, and leukemia have been associated infrequently. One third of those affected will exhibit no systemic disease.

Diagnosis primarily is based on the appearance of the lesions, association with systemic disease, and exclusion of other causes of dermatitis. Histopathologic changes in the early pustule are characteristic and show acute and chronic inflammation in the cutis and necrotic regions. However, histologic examination in the form of biopsy should be avoided since it may initiate new lesions. A standard workup including complete history, physical examination, wound cultures, and serologic tests for syphilis, is warranted.

Due to the idiopathic nature of the disease, therapy is directed at local care and control of systemic disease. Local care serves to prevent secondary infections and to allow healing to occur. Bed rest and nutritional support are mandatory adjuncts to therapy. Gentle wound care with pHisoHexTM soaks, potassium permanganate, or .25 percent acetic acid

solutions along with whirlpool baths help maintain cleanliness and promote healing. Grafting and overzealous debridement are to be avoided since they may exacerbate the condition. More specific therapeutic measures include local corticosteroid injection, topical sodium cromoglycate, and hyperbaric oxygen.

Consideration also must be given to control of concurrent systemic illness. In chronic ulcerative colitis, therapy with sulfapyridine or azulfidine, and/or systemic corticosteroids may be indicated. Other agents used in systemic treatment are clofadimine (experimental in the United States), azathioprine, dapsone, and minocycline. Other therapeutic options include 6-mercaptopurine and cyclophosphamide.

SUMMARY

Pyoderma gangrenosum is an uncommon skin disorder often associated with systemic disease, especially chronic ulcerative colitis (Figures 1, 2, and 3). Therapy is twofold—local care and control of the underlying illness. While the overall prognosis is good and the disease is rarely fatal, pyoderma gangrenosum is physically and mentally crippling with a propensity for recurrence. ■

REFERENCES

1. Moschella SL, Hurley HJ: *Dermatology Second Edition, Volume 1*, 1984.
2. Perry HO: Pyoderma gangrenosum. *South Med J* 62:899-908, 1969.
3. Thorton JR, et al.: Pyoderma gangrenosum and ulcerative colitis. *GUT* 21:247-248, 1980.
4. Greenberg SJ, et al.: Pyoderma gangrenosum: Occurrence with altered cellular immunity and circulating serum factor. *Arch Dermatol* 118:498-502, 1982.
5. Powell FC, et al.: Pyoderma gangrenosum and monoclonal gammopathy. *Arch Dermatol* 119:468-472, 1983.
6. Min Madjlessi SH, et al.: Clinical course and evolution of *Erythema nodosum* and *Pyoderma gangrenosum* in chronic ulcerative colitis: A study of 42 patients. *Am J Gastroenterol* 80:615-619, 1985.
7. Callen JP, Woo TY: Vesiculopustular eruption in a patient with ulcerative colitis. *Arch Dermatol* 121:399-404, 1985.
8. Quigley J, et al.: Pyoderma gangrenosum and ulcerative colitis: Case report and review. *Contemp Surg* 32:91-93, 1988.

AXID®

nizatidine

Enhances compliance and convenience

Patients appreciate Axid, 300 mg, in the Convenience Pak

In a Convenience Pak survey (N = 100)¹

- 100% said the directions on the Convenience Pak were clear and easy to understand
- 93% reported not missing any doses

Pharmacists save time – at no extra cost

- The Convenience Pak saves dispensing time and minimizes handling

The Convenience Pak promotes patient counseling

- Pharmacists dispensing the Axid Convenience Pak can encourage compliance and continued customer satisfaction



Convenience Pak is available at no extra cost



Elil Lilly and Company
Indianapolis, Indiana
46285

AXID®

nizatidine capsules

Brief Summary

Consult the package literature for complete information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg b.i.d. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H₂-receptor antagonists.

Precautions: General – 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests – False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions – No interactions have been observed between Axid and theophylline, chlorzazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,300 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility – A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of endochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of hepatic injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, mice, and female mice given up to 360 mg/kg/day, about 60 times the human dose, and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy – Teratogenic Effects – Pregnancy Category C – Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch belted rabbits at doses up to 56 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers – Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

Pediatric Use – Safety and effectiveness in children have not been established.

Use in Elderly Patients – Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, swelling (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (0.4% vs 0.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic – Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrence of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular – In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS – Rare cases of reversible mental confusion have been reported.

Endocrine – Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic – Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H₂-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumentary – Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity – As with other H₂-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been observed. Because cross-sensitivity in this class of compounds has been observed, H₂-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (e.g., bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Dther – Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

Signs and Symptoms – There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

Treatment – To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the Physicians' Desk Reference (PDR). In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

PV 2096 AMP

[013089]

Additional information available to the profession on request

¹ Data on file, Lilly Research Laboratories

Ciguatera Fish Poisoning

M. ARIF HASHMI, MD
JEFFREY J. SOROKIN, MD
STEPHEN M. LEVINE, MD

The authors describe a case of ciguatera poisoning and the combination of gastrointestinal and neurological symptoms it produces. The ability to assay ciguatoxin in the fish helps in establishing the diagnosis.

Ciguatera fish poisoning is the most common marine intoxication in the United States¹ and more than half the cases of poisoning related to ingestion of seafood are due to ciguatoxin.² While laboratory tests for the detection of ciguatoxin in fish now are available, the diagnosis in humans is made clinically by recognizing the peculiar combination of gastrointestinal and neurological symptoms produced by ciguatoxin.

Dr. Hashmi is clinical assistant professor of medicine, Dr. Sorokin is clinical associate professor of medicine, and Dr. Levine is clinical professor of medicine, Cooper Hospital/University Medical Center, Camden. Requests for reprints may be addressed to Dr. Hashmi, 1210 Brace Road, Cherry Hill, NJ 08034.

With the advent of ease of refrigeration and transportation of fish, cases of ciguatera fish poisoning no longer are confined to the southeastern seaboard. We present a case of ciguatera fish poisoning that occurred in southern New Jersey.

CASE REPORT

A 40-year-old female presented at the emergency room complaining of nausea, vomiting, and neurological symptoms consisting of paresthesias, manifesting as tingling and pins and needles sensations of her extremities, blurred vision, and involuntary laughing and crying. These symptoms started two hours after eating seafood at a local restaurant. Her past medical history included irritable bowel syn-

drome, lactose intolerance, deafness due to streptomycin, fibroadenomatosis of the breasts, hysterectomy, appendectomy, and surgical correction of strabismus. She had been taking hyoscyamine and lactase supplements for many months and denied smoking, using illicit drugs, or drinking in excess. In the emergency room, her physical examination was reported as unremarkable although involuntary movements of the extremities were noted. A neurological consultant noted anisocoria, which he thought was congenital, diminished pain and touch sensation in the right upper and lower extremities, a narrow right palpebral fissure, and lumbosacral tenderness. Cranial nerves, vibration sense, and deep tendon reflexes were normal.

A diagnosis of cerebrovascular accident was entertained, but a computed tomography (CT) scan of the brain and an electroencephalogram were normal, as were the serum electrolytes, glucose, calcium, renal function tests, liver chemistries, and hemoglobin. The sedimentation rate was 20 mm during the first hour by the Westergren method and the antinuclear antibody test was negative. The white blood count (WBC) was 18,000 per cubic mm on admission, and the differential count showed 80 percent neutrophils, 7 percent lymphocytes, 3 percent atypical lymphocytes, 3 percent monocytes, and 7 percent eosinophils. The WBC fell to 8,800 over the next 24 hours, but the eosinophils rose to 18 percent of the WBC. Stool examination did not reveal enteric pathogens, and urine specimen tested free of drugs.

The patient was treated with intravenous fluids while she fasted. Over the next 48 hours, her nausea and vomiting subsided. She was discharged on hospital day ten with diminished, but persistent, paresthesias.

Two months after hospital discharge, the patient complained of dysarthria and paresthesias of the right upper extremity. Examination revealed diminished sensation in that extremity. There were no gastrointestinal complaints. The eosinophil count was 6 percent of the WBC. A presumptive diagnosis of ciguatera fish poisoning was made.

One month later, another neurology consultant diagnosed C5-6 radiculopathy in the right arm. Over the following two months, the neurological symptoms subsided completely and there has been no recurrence after one year.

DISCUSSION

Ciguatoxin is a lipid-soluble, tasteless, odorless, colorless, and acid and heat stable toxin produced by the dinoflagellate, *Gambierdiscus toxicus*.^{3,4} Low concentrations of the toxin are ingested and accumulate in the muscles and viscera of small herbivorous fish that feed on these micro-algae. The

toxin accumulation reaches significant concentrations in large carnivorous fish that feed on the smaller fish. Human intoxication occurs when the larger fish are eaten.^{5,6} The neurological effects of the toxin are thought to be caused by its ability to depolarize cell membranes by increasing their permeability to sodium.^{7,8} The highest concentrations of ciguatoxin are found in the viscera and many of the fatal cases have occurred after ingestion of fish viscera, especially the liver.⁸⁻¹⁰ The majority of cases of ciguatera poisoning in the United States have been due to ingestion of barracuda, grouper, mackerel, and similar coral reef fish.^{5,6} The toxin does not affect the fish and there are no alterations in their flesh that would signal the presence of the ciguatoxin.

Most bioassays used to detect the toxin lack specificity and sensitivity, or are expensive and time consuming. A recently developed, rapid, inexpensive, and accurate stick test¹¹ that detects the toxin in the fish now is available through the University of Hawaii. An enzyme-linked immunosorbent assay (ELISA) also is being developed by the Food and Drug Administration.

The clinical features of ciguatera poisoning in humans consists of a combination of gastrointestinal and neurological symptoms. However, in one report, this combination was found in only 53 percent of the cases.² The incubation period is from a few minutes up to 30 hours. The attack rate has been reported from 73 to 100 percent,^{2,12} but the mortality is less than 1 percent.⁸

The first symptoms usually appear between 2 and 6 hours after ingestion of the ciguatoxin. They usually are gastrointestinal and consist of diarrhea in 70 to 90 percent, vomiting in 40 to 70 percent, nausea in 40 to 50 percent, and abdominal cramps. These are short lived and have a median duration of 12 hours.²

Soon after the onset of gastrointestinal symptoms,

Ciguatera. Poisoning due to the ingestion of the flesh or viscera of various marine fish of the tropical Caribbean and Pacific, such as barracuda, grouper, red snapper, amberjack, and dolphin, which contain ciguatoxin that is acquired through their food chain and is unaffected by preservation or preparation procedures; it is characterized by varying combinations of vomiting and diarrhea, myalgia, dysesthesia and paresthesia of the extremities and perioral region, pruritis, headache, weakness, and diaphoresis.

*Stedman's Medical Dictionary, 24th Edition, 1982.

neurological symptoms appear; they may persist for weeks or months. The most common neurological symptoms, occurring in 90 percent of the cases, are paresthesias, which commonly affect the extremities. Two peculiar forms have been noted. One is the reversal of temperature sensation where the patient experiences a burning or hot sensation on touching cold objects. The other is the oral and circumoral location of dysesthesias. Myalgias, pareses, headaches, and ataxia also occur. Pruritis occurs in up to 45 percent of cases,¹⁰ especially after activities such as exercise and alcohol ingestion,^{3,12} which increase the skin blood flow.

Bradycardia and hypotension occur rarely and are seen in severe cases where large amounts of toxin have been ingested. However, most fatalities are due to respiratory failure from paresis of the respiratory muscles.^{8,13}

The treatment of ciguatera poisoning primarily is symptomatic and supportive. A recent report¹⁶ describes dramatic improvement in the severity and duration of symptoms in 24 patients given intravenous mannitol. Anecdotal reports have described improvement in symptoms with amitriptyline hydrochloride, pralidoxime chloride, and to-cainide,¹⁷ but none has proved efficacy. No definite benefit has been described with calcium infusions, vitamins, anticholinesterases, and corticosteroids. Atropine should be used for symptomatic bradycardia. In severe cases, ventilatory assistance may be necessary.

Patients should be advised against eating fish for three to six months after all symptoms have

subsided because exposure to the ciguatoxin does not confer immunity. In fact, symptoms tend to be more severe upon re-exposure.^{4,10,12}

We present this case to alert the New Jersey medical community of the potential for ciguatera poisoning to occur in nonendemic areas. Our case was somewhat unusual because the neurological symptoms were predominantly unilateral, and transient eosinophilia occurred. It is important to be familiar with this entity so that once the diagnosis is reasonably established, further gastrointestinal and neurological investigations are recognized to be unnecessary. In addition, the patient can be reassured that the neurological symptoms are not permanent. With the advent of the stick test, rapid confirmation of the presence of the toxin in the fish now has become possible.

SUMMARY

Cases of ciguatera fish poisoning no longer are confined to endemic areas. This makes awareness of this entity important. The diagnosis usually is made by the presence of gastrointestinal symptoms, nausea, vomiting, and diarrhea, and of neurological symptoms such as paresthesias, paresis, and pruritis. The detection of ciguatoxin in the ingested fish by any of the available bioassays, will confirm the diagnosis. The treatment of this food poisoning is supportive, although intravenous mannitol is reported to be safe and effective. The prognosis is good and complete recovery is to be expected. However, relapses can occur, especially on re-exposure to the toxin. ■

REFERENCES

1. Morris JG, Lewin P, Hargrett NT, et al.: Clinical features of ciguatera fish poisoning. *Arch Intern Med* 142:1090-1092, 1982.
2. Engleberg NC, Morris JG, Lewis J, et al.: Ciguatera fish poisoning: A common source outbreak in the U.S. Virgin Islands. *Ann Intern Med* 98:336-337, 1983.
3. Pearce R, Hines C, Burns T, et al.: Ciguatera (fish poisoning). *South Med J* 76:560-561, 1983.
4. Emerson DL, Galbraith RM, McMillan JP, et al.: Preliminary immunologic studies of ciguatera poisoning. *Arch Intern Med* 143:1931-1933, 1983.
5. Centers for Disease Control: Ciguatera fish poisoning-Vermont. *MMWR* 16:2727, 1986.
6. Centers for Disease Control: Ciguatera fish poisoning-Bahamas, Miami. *MMWR* 31:391-392, 1982.
7. Bidard J-N, Vijverberg HP, Frelin C, et al.: Ciguatoxin is a novel type of Na⁺ channel toxin. *J Bio Chem* 259:8353-8357, 1983.
8. Withers NW: Ciguatera fish poisoning. *Ann Rev Med* 33:97-111, 1982.
9. Ho AM, Fraser IM, Todd EC: Ciguatera poisoning: A report of three cases. *Ann Emerg Med* 15:1225-1228, 1986.
10. Bagnis R, Kuberski T, Laugier S: Clinical observations on 3,009 cases of ciguatera (fish poisoning) in the South Pacific. *Am J Trop Med Hyg* 28:1067-1073, 1979.
11. Hokama Y: A rapid, simplified enzyme immunoassay stick test for the detection of ciguatoxin and related polyethers from fish tissues. *Toxicon* 23:939-946, 1985.
12. Lawrence DN, Enriquez MB, Lumish RM, et al.: Ciguatera fish poisoning in Miami. *JAMA* 244:254-258, 1980.
13. Chretien JH, Fermaglieh J, Garagusi VF: Ciguatera poisoning. *Arch Neurol* 38:783, 1981.
14. Morris JG, Lewin P, Smith CW, et al.: Ciguatera fish poisoning: Epidemiology of the disease on St. Thomas, U.S. Virgin Islands. *Am J Trop Med Hyg* 31:574-478, 1982.
15. Tatnall FM, Smith HG, Welsby PD, et al.: Ciguatera poisoning. *Br Med J* 281:948-949, 1980.
16. Palafon NA, Jain LG, Pinano AZ, et al.: Successful treatment of ciguatera fish poisoning with intravenous mannitol. *JAMA* 259:2740-2742, 1988.
17. Lange WR, Kreider SD: Potential benefit of to-cainide in the treatment of ciguatera: Report of three cases. *Am J Med* 84:1087-1088, 1988.

When it comes to your patients' health leave no stone unturned.



Lithotripsy at The New Jersey Kidney Stone Treatment Center can be the alternative.

Convenience—The New Jersey Kidney Stone Treatment Center is centrally located in downtown New Brunswick, near major highways, for easy access for you and your patients.

Flexible scheduling—The Center offers scheduling with no delay. In most cases, your patient can be treated within a week of your call. Our extended hours allow you to make appointments at the convenience of both you and your patients.

Bath-free equipment—The Center is equipped with the most advanced Dornier HM4 lithotripter, eliminating the need for a water bath, allowing for easier patient handling and greater patient comfort. Also in use is a state-of-the-art Shimadzu Hydrojust III cystoscopy table.

Experienced, professional staff—The staff of the New Jersey Kidney Stone Treatment Center is well-versed in lithotripsy treatment, and includes board-certified Anesthesiologists, critical-care trained nurses and skilled lithotripsy technicians.

Physician billing—Urologists treating patients at the Center have the advantage of billing their patients or third-party payers directly through their own offices.

Easy referral system—If desired, physicians can easily refer their patients to one of our staff Urologists for lithotripsy treatment.

HMO eligibility—The Center has established arrangements with most major area HMO's.

For more information regarding how the Center can help you and your kidney stone patients, call 1-800-542-8887 or (201) 937-8614.

New Jersey Kidney Stone Treatment Center

**Located at Robert Wood Johnson University Hospital
New Brunswick, New Jersey 1-800-542-8887**

The New Jersey Kidney Stone Treatment Center is operated by Health Harizans (ESWL), L.P., affiliated with the following hospitals: Community Memorial Hospital, Freehold Area Hospital, Helene Fuld Medical Center, Jersey Shore Medical Center, Raritan Bay Medical Center, Riverview Medical Center, Robert Wood Johnson University Hospital, St. Francis Medical Center, St. Peter's Medical Center, Somerset Medical Center.

Aseptic Synovitis

J.G. BARONE, MD

C.J. WANG, MD

J.E. BARONE, MD

We report the first case of aseptic synovitis that occurred after a titanium knee prosthesis failed. This complication should be considered when a patient with a titanium prosthesis develops tenderness, erythema, and swelling of that joint.

Titanium knee prostheses have been in use since 1951. They are inert and biocompatible.¹ No clinically significant inflammatory reactions to these implants have been reported. In this patient, a florid aseptic synovitis occurred after a titanium knee implant failed.

CASE REPORT

A 70-year-old male with severe degenerative joint disease underwent porous-coated anatomical total knee arthroplasty in November 1986. Three months postoperatively, the knee became erythematous,

Drs. J.G. Barone, Wang, and J.E. Barone are affiliated with the section of orthopaedics, Department of Surgery, St. Francis Medical Center, Trenton. Requests for reprints may be addressed to Dr. J.E. Barone, Department of Surgery, St. Francis Medical Center, 601 Hamilton Avenue, Trenton, NJ 08629.

warm, and painful. The patient was afebrile; white blood cell count was normal. Six weeks of knee immobilization and antibiotics did not improve his symptoms. X-rays and computed tomographic scan were normal.

The knee was explored in December 1987, because of progressive symptoms. All admitting laboratory data were normal. At surgery, thick black tissue covered the entire joint capsule (Figure 1). The high molecular weight plastic patellar dome had completely separated from its metallic base. A metal to metal interface was created between the metal patellar base and the metallic femoral component. Severe wear of the metallic patellar base was seen (Figure 2).

Cultures were taken and all black tissue was debrided. The worn metallic patella base was removed. A plastic patella was cemented in place. The

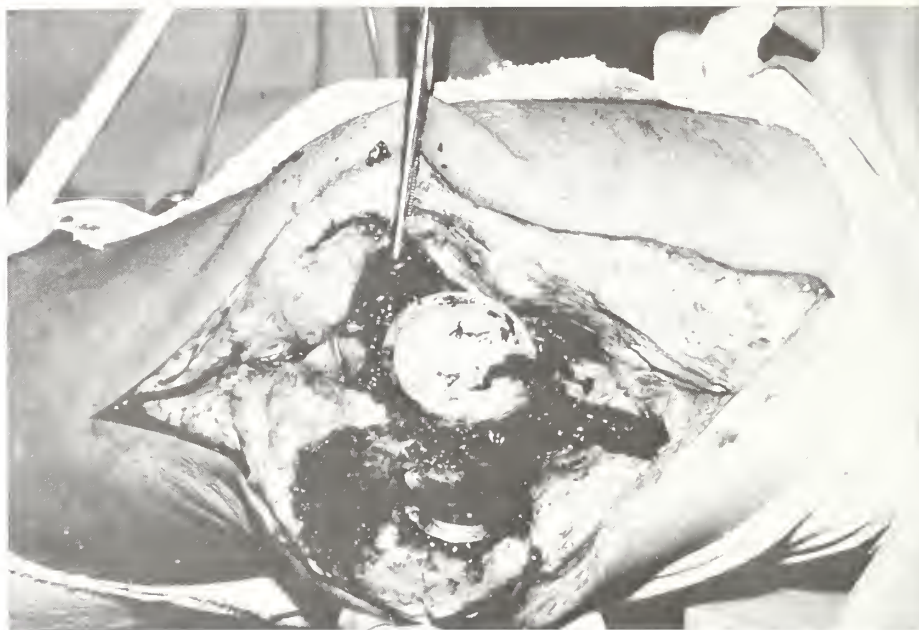


Figure 1. Thick black tissue covered the entire joint capsule.

wound was irrigated and closed. Ten months postoperatively, the patient is doing well. Antibiotics were not used postoperatively.

Intraoperative cultures were negative. Microscopic findings demonstrated a florid foreign body tissue reaction with giant cell formation (Figure 3). Metallurgic analysis revealed a severe synovitis secondary to small metallic particles in the synovial tissues.

DISCUSSION

Studies have demonstrated the presence of small shed particles of titanium adjacent to titanium knee implants.² They are generated through the mechanisms of wear, corrosion, and diffusion. These par-

ticles enter the synovial tissues where they undergo phagocytosis by macrophages.² Usually, minimal tissue reaction is found.

In this case, separation of the metallic and plastic patellar components created a metallic patella to metallic femur interface. Frictional forces were increased which produced an enormous load of shed particles. This load and the long duration of exposure to those particles resulted in a severe synovitis.

This is the first case report of a clinically significant titanium-induced synovitis. Physicians should consider this rare complication if a patient with a titanium knee suddenly develops pain and erythema of that joint. ■

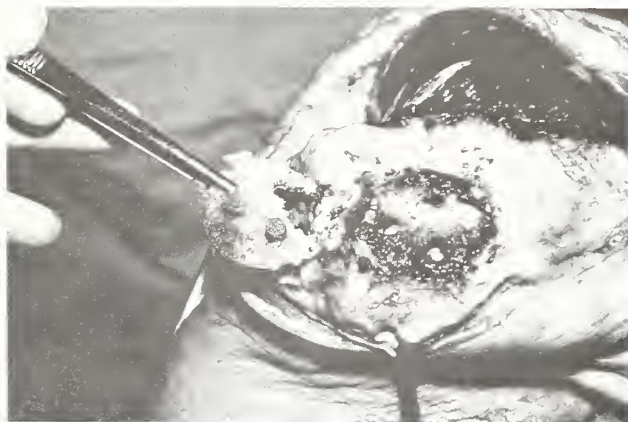


Figure 2. Severe wear of the metallic patellar base was seen.

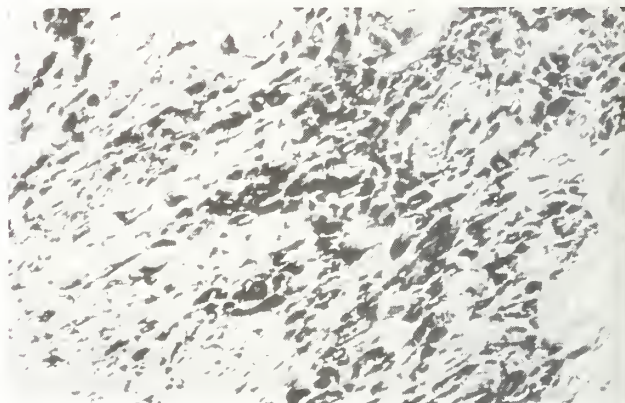


Figure 3. Microscopic findings demonstrated a florid foreign body tissue reaction with giant cell formation.

REFERENCES

1. Dobbs HS: Survivorship of worn hip replacements. *J Bone Joint Surg* 62:71-79, 1980.
2. Rae T: A study on the effects of particulate metals

of orthopaedic interest on murine macrophages in vitro. *J Bone Joint Surg* 57:445-450, 1974.

Varicella Pneumonia in the Adult

JOHN A. CONTI, MD
MONROE S. KARETZKY, MD

Varicella pneumonia is a common complication of chickenpox in the adult. It is potentially serious and the degree of impairment in gas exchange may be unrelated to the initial clinical picture. Treatment consists of drug administration and supportive care.

Varicella pneumonia generally is assumed to be an unusual, benign complication of varicella-zoster infection in the adult. Because of the severe impairment in gas exchange observed, we thought it appropriate to report our experience. The pathology, epidemiology, clinical course, and treatment of this uncommon but potentially fatal complication will be reviewed.

CASE REPORT

A 32-year-old male of Indian descent from Guyana was admitted with a one-week history of rash and productive cough. Five days prior to admission, the rash began as a pustular eruption on the anterior chest wall; over succeeding days, it appeared on the face, neck, back, and extremities. The evolution of the rash from pustule to crusting was variable in each area. Two days following its onset, the patient began to have a cough, productive of blood-streaked sputum, and associated with dyspnea at rest, pleuritic chest pain, fever, and night sweats. He had no known allergies nor abnormal medical history. He could not recall childhood diseases. Exposure to chickenpox occurred one week before the onset of complaints. He took no medications except calamine lotion and acetaminophen. His medical, social, and

Drs. Conti and Karetzky are affiliated with Newark Beth Israel Medical Center. Requests for reprints may be addressed to Dr. Karetzky, Department of Pulmonary Medicine, Newark Beth Israel Medical Center, 201 Lyons Avenue, Newark, NJ 07112.

family history was noncontributory except for his being a cigarette smoker for 15 years.

Physical examination revealed a well-developed man in mild respiratory distress. His vital signs were: T37.5° C, HR 60 beats/min, BP 124/70 mmHg, f 20 breaths/min. His skin showed multiple pustular and vesicular lesions in different stages of healing. Further inspection showed an erythematous pharynx with enlarged tonsils but no exudates; on auscultation of the chest, basilar rales were heard bilaterally. The remainder of the examination was normal. Laboratory findings included ESR 60 mm/hour, Hb 16 gm/dl, WBC 10,500/mm³ showing lymphocytic predominance (63 percent with 14 percent atypical forms), and a platelet count of 125,000/mm³. Routine chemistries and a coagulation profile were normal. An arterial blood gas sample obtained while breathing room air showed P_{O₂} 59 mmHg; P_{CO₂} 36 mmHg and pH 7.40. The chest x-ray revealed a diffuse interstitial infiltrate (Figure 1); electrocardiogram was normal. The patient, assessed as having varicella pneumonia, developed a low-grade fever and was started on acyclovir intravenously 500 mg every eight hours. Though his arterial P_{O₂} while breathing room air fell to 53 mmHg, his overall clinical picture improved with resolution of rash, cough, and dyspnea the following day. He was given a five-day course of intravenous acyclovir and discharged on hospital day six with no medication. Repeat chest x-ray showed clearing of the pneumonia (Figure 2). A pulmonary function test

CASE REPORT

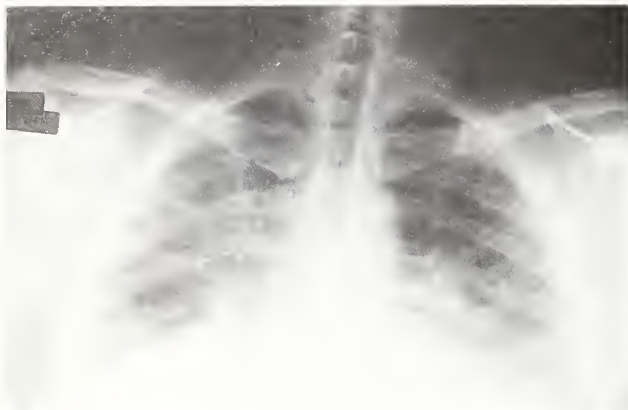


Figure 1. Admitting chest x-ray showing bilateral diffuse infiltrates.

at this time, however, indicated the persistence of a restrictive ventilatory defect with a disproportionate degree of impairment in gas exchange as reflected by the decreased diffusing capacity. Repeat testing three months later showed significant improvement in all values to normal or near normal levels (Figure 3).

DISCUSSION

The varicella-zoster virus is a double-stranded DNA virus of the herpes family. Primary infection with the organism results in chickenpox and can occur via direct contact with varicella or zoster lesions or by inhalation of respiratory secretions.¹ After an incubation period ranging from 9 to 21 days, the onset of disease usually is heralded by the appearance of the characteristic rash. Varicella is a highly contagious disease characterized by fever and a disseminated vesicular rash.² More commonly, it is known as chickenpox and classically is a childhood infection with less than 2 percent of the cases each year occurring in patients over age 20.³ This is fortunate; while the disease usually runs a benign course in children, it often is more severe in adults with a higher incidence of complications. The older age group comprises 17 percent of the varicella cases requiring hospitalization, with pneumonia representing the most common serious complication in the adult.^{1,3} Varicella pneumonia has been reported to occur in 16 to 50 percent of adult cases.^{4,6} Pneumonia occurs more frequently in both children and adults who are immunologically compromised or otherwise at special risk. This group includes those with AIDS or malignancies (especially leukemias and lymphomas) and patients receiving immunosuppressive drugs, including corticosteroids.¹ Pregnant women also appear to be predisposed.^{7,8} Varicella pneumonia has been reported to be more severe and to have greater mortality in otherwise healthy pregnant women but the pathogenesis of



Figure 2. Discharge x-ray showing clearing of pneumonia on hospital day six.

this phenomenon remains unexplained.^{7,8} An association between cigarette smoking, as noted in our patient, and a predisposition to varicella pneumonia has been reported.⁹ A similar casual relationship of excess pulmonary morbidity and smoking has been reported to occur in influenza.¹⁰

The clinical course is quite variable, ranging from asymptomatic infection diagnosed radiographically to fulminant respiratory failure and death. The respiratory symptoms may precede the rash, but usually the symptoms present one to six days after onset; they consist of cough, dyspnea, fever, pleuritic chest pain, and hemoptysis. Physical findings can be minimal and, as with other pneumonias, correlate poorly with the severity of the disease as determined by clinical course and objective measures of lung function. Radiographically, the acute process is associated with a diffuse nodular infiltrate with a prominent peribronchial distribution. Other possible features include dense reticular markings, pleural effusions, and hilar adenopathy. The histologic picture of varicella pneumonia consists of endothelial damage in small blood vessels resulting in focal hemorrhagic necrosis, mononuclear infiltration of alveolar walls with macrophages, and fibrinous exudates with macrophages in the alveoli.¹¹ The pneumonia occasionally can present as a military infiltrate on chest x-ray reflecting granulomatous lesions seen on histological examination.¹¹ Upon recovery, the necrotic foci may calcify remaining, thereafter, as an incidental radiological marker. The differential diagnosis includes other viral diseases, especially herpes simplex, secondary bacterial infections, and the gamut of opportunistic organisms

CASE REPORT

to be considered when pneumonia is present in an immunocompromised patient. The diagnosis, however, is straightforward in the presence of the characteristic chickenpox rash accompanying the respiratory symptoms, a radiographic pattern consistent with a viral pneumonia, and a contact history of exposure to chickenpox or shingles.

The natural history of varicella pneumonia usually consists of complete recovery within seven to ten days without treatment. Recovery correlates well with the clearing of skin lesions. The clinical course, however, is unpredictable and sometimes can be accompanied by the acute lung injury syndrome and requires intubation (with or without mechanically assisted ventilation) in order to provide inspired oxygen concentrations high enough to maintain adequate arterial oxygenation. Mortality rates have ranged from 10 to 40 percent, with the higher figures representing immunosuppressed patients and pregnant women.^{7,12-14} In previously healthy adults, no factors have been identified which predict a more virulent course, so all cases must be considered potentially fatal and monitored closely.

Traditionally, the treatment of varicella pneumonia consisted solely of supportive care. In the 1980s, however, apparently effective antiviral agents have become available.¹⁵ The two compounds which have been found to have significant activity against the varicella-zoster virus are the guanosine and adenine nucleoside analogues, acyclovir and vidarabine, respectively, that interfere with viral replication. Studies assessing the efficacy of these agents in immunosuppressed patients with varicella have demonstrated decreased morbidity from visceral dissemination in patients receiving the drugs versus those receiving placebo.^{16,17} Few controlled studies, however, have been conducted on the use of antiviral agents in varicella infection in the normal host. One such effort noted a decrease in duration of fever but no alteration in viral shedding or rate of lesion healing in a comparison of intravenous acyclovir versus placebo in adults with varicella.¹⁸ This study did not include any patients with visceral disease. Others report successful treatment of varicella pneumonia with antiviral agents (usually acyclovir) in immunosuppressed,^{16-17,19-20} pregnant,²¹⁻²⁴ and normal^{2,25-28} hosts with severe disease. Some have advocated the use of high-dose acyclovir in all cases of varicella pneumonia to prevent subsequent respiratory morbidity.^{25,27,28} However, no controlled studies have demonstrated the unequivocal benefit of antiviral agents in the treatment of varicella pneumonia in the normal host, let alone in prophylaxis. Although acyclovir is used more widely, only one study has clearly shown it to be better than vidarabine.²⁰ This unconfirmed study was conducted

among immunosuppressed patients and a comparative trial in the normal host remains to be done. Delay in the onset of therapy, rather than the choice of a particular antiviral agent, has been proposed as the critical factor.²⁹ The current recommendations for the treatment of varicella pneumonia with acyclovir are 500 mg/m² body surface area, every eight hours, intravenously for seven days in normal hosts, and for an additional three days in the immunosuppressed host.¹ This represents a high dose of the drug, much higher than the dose used to treat herpes simplex virus infections, which are more sensitive to the drug.¹ Acyclovir, in contrast to vidarabine, has the potential for nephrotoxicity. This is due to precipitation of the drug in the kidneys, resulting in a crystalline nephropathy, which usually is reversible.³⁰ The risk of this complication can be minimized by slow infusion of the drug, vigorous hydration, and close monitoring of serum creatinine. It remains to be proved whether the risks of treatment in the normal host will be outweighed by the inferred benefits of reducing morbidity and mortality. Inhalation therapy utilizing the synthetic nucleoside ribavirin, which has been reported to be effective in respiratory syncytial virus³¹⁻³⁴ and in influenza,³⁵ has not been evaluated for acyclovir or vidarabine.

SUMMARY

Chickenpox pneumonia can occur in as many as half of the varicella-zoster infections in adults.

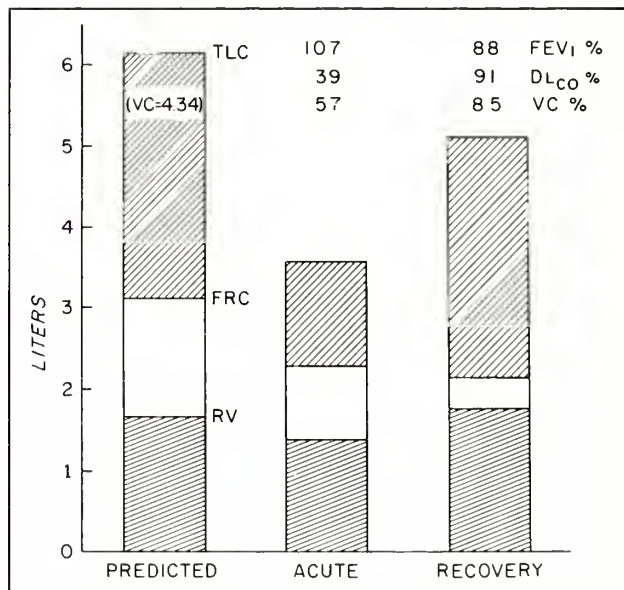


Figure 3. Pulmonary function testing depicted graphically indicating: TLC = total lung capacity; FRC = functional residual capacity; RV = residual volume; FEV₁ % = FEV₁/VC; DL_{CO} % = diffusing capacity % predicted and VC = vital capacity and VC % = % predicted. The acute restrictive ventilatory defect resolved when measurements were repeated three months later. Arterial oxygenation increased to 74 mmHg. The patient continued to smoke with HbCO 6.7%.

CASE REPORT

Although it usually exhibits a benign course, this complication can cause considerable morbidity and mortality in predisposed groups, including pregnant women and immunosuppressed patients. In these patients, the use of antiviral drugs, most notably acyclovir, has been shown to lessen the morbidity of varicella-zoster infections. Early diagnosis of lung involvement from the chest x-ray or arterial blood

gas measurements, even in the absence of symptoms, is essential for optimum efficacy of drug therapy. The use of acyclovir in normal hosts continues to be debated, especially for prophylaxis, because of its potential for nephrotoxicity. Judicious use of acyclovir will reduce the overall mortality from this potentially fatal complication of varicella-zoster virus infection. ■

REFERENCES

1. Straus SE: Varicella-zoster virus infections: Biology, natural history, treatment, and prevention. *Ann Intern Med* 108:221-227, 1988.
2. Hochberger RS, Rothstein RJ: Varicella pneumonia in adults—a spectrum of disease. *Ann Emerg Med* 15:931-934, 1986.
3. Guess HA, Broughton DD, Melton LJ III, Kurland LT: Population-based studies of varicella complications. *Pediatrics* 78:723-727, 1986.
4. Mermelstein RH, Freireich AW: Varicella pneumonia. *Ann Intern Med* 55:456-463, 1961.
5. Seltzer RA: Varicella pneumonia. *Dis Chest* 45:210-214, 1964.
6. Weber DM, Pellicchia JA: Varicella pneumonia—study of prevalence in adult men. *JAMA* 192:572-573, 1965.
7. Harris RE, Rhoades ER: Varicella pneumonia complicating pregnancy—case report and review of the literature. *Obstet Gynecol* 25:734-736, 1965.
8. Paryani SG, Arvin AM: Intrauterine infection with varicella-zoster virus after maternal varicella. *N Engl J Med* 314:1542-1546, 1986.
9. Ellis ME, Neal KR, Webb AK: Is smoking a risk factor for pneumonia in adults with chickenpox? *Br Med J* 294:1002, 1987.
10. Kark JD, Lebiush M, Rannon L: Cigarette smoking as a risk factor for epidemic A(H₁N₁) influenza in young men. *N Engl J Med* 307:1042-1046, 1982.
11. Meyer B, Stalder H, Wegmann H: Persistent pulmonary granulomas after recovery from varicella pneumonia. *Chest* 89:457-459, 1986.
12. Fleischer G, Henry W, McSorley M, et al.: Life-threatening complications of varicella. *Am J Dis Child* 135:896-899, 1981.
13. MacFarlane JF, Smith FD, Finch RG, et al.: Vidarabine in fulminating chickenpox pneumonia. *Thorax* 37:226-227, 1982.
14. Treibruasser JH, Harris RE, Bryant RE, et al.: Varicella pneumonia in adults—report of seven cases and review of the literature. *Medicine* 46:409-423, 1967.
15. VanDer Meer JWM, Thompson J, Wie Dijn Tan, et al.: Treatment of chickenpox pneumonia with acyclovir. *Lancet* II:473-474, 1980.
16. Prober CG, Kirlo LE, Keeney RE: Acyclovir therapy of chickenpox in immunosuppressed children: A collaborative study. *J Pediatr* 101:622-625, 1982.
17. Whitley R, Hilty M, Haynes R, et al.: Vidarabine therapy of varicella in immunosuppressed patients. *J Pediatr* 101:125-131, 1982.
18. Al-Nabib W, Al-Kandari S, El-Khalik DM, et al.: A randomized controlled study of intravenous acyclovir (Zovirax®) against placebo in adults with chickenpox. *J Infection* 6:49-56, 1983.
19. Balfour HH Jr, Beam B, Laskin OL, et al.: Acyclovir halts progression of herpes zoster in immunocompromised patients. *N Engl J Med* 308:1448-1453, 1983.
20. Shepp DH, Dandliker PS, Meyers JD: Treatment of varicella-zoster virus infection in severely immunocompromised patients—a randomized comparison of acyclovir and vidarabine. *N Engl J Med* 314:208-212, 1986.
21. Landsberger EJ, Hager WD, Grossman JH III: Successful management of varicella pneumonia complicating pregnancy. *J Reprod Med* 31:311-314, 1986.
22. Hankins GD, Gilstrap LC III, Patterson AR, et al.: Acyclovir® treatment of varicella pneumonia in pregnancy. *Crit Care Med* 15:336-337, 1987.
23. Boyd K, Walker E: Use acyclovir to treat chickenpox in pregnancy. *Br Med J* 296:393-394, 1988.
24. Eder SE, Apuzzio JJ, Weiss G: Varicella pneumonia during pregnancy. Treatment of two cases with acyclovir. *Am J Perinatol* 5:16-18, 1987.
25. Chitkara R, Gordon RE, Khan FA: Acyclovir® in the treatment of primary varicella pneumonia in nonimmunocompromised adults. *NY State J Med* 87:237-238, 1987.
26. Gaussorgues P, Robert D, Petramond D: Acute respiratory distress syndrome in chickenpox in three healthy adults. *Ann Med Intern* 138:289-290, 1987.
27. Lheureux PH, Dautrepoint JM, Askenasi R: Varicella pneumonia in adulthood—acyclovir therapy may be of benefit. *Ann Emerg Med* 16:1097, 1987.
28. Schlossberg D, Littman M: Varicella pneumonia. *Arch Intern Med* 148:1630-1632, 1988.
29. Davidson RN, Lynn W, Savage P, et al.: Chickenpox pneumonia—experience with antiviral treatment. *Thorax* 43:627-630, 1988.
30. Dorsky DI, Cumpacker CS: Drugs five years later—acyclovir. *Ann Intern Med* 107:859-874, 1987.
31. Taber LH, Knight V, Gilbert BE, et al.: Ribavirin aerosol treatment of bronchiolitis associated with a respiratory syncytial virus infection in infants. *Pediatrics* 72:613-618, 1983.
32. Hall CB, McBride JT, Walsh EE, et al.: Aerosolized ribavirin treatment of infants with respiratory syncytial viral infection. A randomized double-blind study. *N Engl J Med* 308:1443-1447, 1983.
33. Hall CB, Walsh EE, Hruska JF, et al.: Ribavirin treatment of experimental respiratory syncytial viral infection: Controlled double-blind study in young adults. *JAMA* 254:2666-2670, 1985.
34. Hall CB, McBride JT, Gala CL, et al.: Ribavirin treatment of respiratory syncytial viral infection in infants with underlying cardiopulmonary disease. *JAMA* 254:3047-3051, 1985.
35. Knight V, McClung HW, Wilson SZ, et al.: Ribavirin small-particle aerosol treatment of influenza. *Lancet* 2:945-949, 1981.

NOTEBOOK

TRUSTEES' REPORT

A regular meeting of the Board of Trustees was held on Sunday, April 9, 1989, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions of the Board follows:

NJ Commissioner of Health . . .

Noted comments by Dr. Molly Coye on the following: proposed nursing home regulations; the decision to meet with physicians and representatives of the New Jersey Hospital Association to develop a means to strengthen peer review and to formulate guidelines for the procedure of cesarean sections; uncompensated care and recommendations for compensating physicians; and certificate of need legislation and a study group including representatives of MSNJ planned to discuss the issue. Also, voted to support the efforts of the Department of Health in the development of regulations regarding withholding or withdrawing of life-sustaining procedures in nursing homes.

Report of Executive Director . . .

(1) MSNJ Membership . . .

Noted that as of March 31, 1989, there was a total of 6,529 paid memberships.

(2) MSNJ Financial Statements . . .

Reviewed and approved the financial statements for the period ending February 28, 1989.

(3) Proposed No-Fault Fee Schedule . . .

Voted to notify the commissioner of insurance that, because of the numerous inac-

curacies, the proposed fee schedule is inappropriate, and to offer the expertise of the Society in developing a more meaningful schedule. Further directed that a committee within the Board be established to advise Mr. Maressa concerning the appropriateness of the various diagnoses and the commendations to be made to the commissioner of insurance.

(4) Medical Discipline and Licensing—S-2936 . . . Noted that a technical markup session to present further amendments to the legislation will be held on April 13, 1989.

(5) State Board of Medical Examiners . . . Noted that Mr. Maressa has filed a letter of appeal with the State Board of Medical Examiners suggesting that until a formal rule is adopted, the State Board should continue its prior policy concerning certified registered nurse anesthetists. Also, will be apprised of developments concerning the authorization of physician assistant functions.

(6) Medical Malpractice Surcharge Proposal . . . Noted that MSNJ is awaiting a response from the commissioner of insurance concerning the surcharge.

UMDNJ Report . . . Noted the following items from the report of Stanley S. Bergen, Jr, MD: expanding specialized services for the elderly including dental services and a respite program for families of individuals with Alzheimer's disease; the honoring of Dr. Bergen by UMDNJ's Board of Concerned Citizens; research grants awarded to UMDNJ; a rare

medical textbook exhibit at George F. Smith Library; establishment of a Department of Family Medicine; commencement exercises on May 24, 1989; closing of the Fairleigh Dickinson University Dental School; and a budget cut of \$4.3 million from the UMDNJ budget for the last four months of this year.

NJ Hospital Association . . .

Noted the following items from the report of Louis P. Scibetta: graduate medical education and reimbursement reform; proposed living will regulations which will impact on the authority of the ombudsman for the institutionalized elderly; medical waste legislation, awaiting Governor Kean's signature, which would make the manifest system law, impose stiff penalties on violators, and limit hospital exposure to liability for improper disposal when it occurs outside hospital jurisdiction; support of A-267 which would require hospitals dispensing drugs and durable medical equipment through a for-profit affiliate, or providing other home health services, to furnish discharged patients with written notice of three other providers of pharmaceutical services; proposed reductions in Medicare funding; legislation to upgrade the wages of New Jersey hospital workers; the new president and chief executive officer of the Hospital Association, Joseph M. Galvin, Jr; opportunities for Irish nurses to travel to the United States to work in specified hospitals and ultimately to obtain licensure; and an educational campaign to inform the public about

the problems facing hospitals today.

Council on Legislation . . . Approved the following recommendations:

That the Board of Trustees approve the positions recommended by the Council on Legislation on the action deferred bills.

That the Board of Trustees approve the positions recommended by the Council on Legislation.

Special Committee To Review S-216 and Similar Legislation . . . Approved the following recommendation:

That the position on S-216 be changed to No Action.

Noted that two lists of legislation now will be presented: the active list and the monitor list.

Council on Medical Services . . .

(1) 1987 Resolution #13—Disability Benefit Forms . . . Adopted the first recommendation and approved the second recommendation:

(1) That 1987 Resolution #13, Disability Benefits Forms, be approved.

(2) That the Board of Trustees communicate in writing to the New Jersey Department of Labor (E. Lorraine Gibbs, Medical Relations Officer, Division of Disability Determinations) the inadequate fee to physicians for completing the medical report forms for the Social Security Disability Benefits Program and the lack of adjustments since its inception. It should be noted that these medical reports have become progressively more burdensome. It should be requested that they increase the fee to \$50.

(2) Resource-Based Relative Value Scale . . . Approved the following recommendation:

The Medical Society of New Jersey recognizes Report AA of the AMA Board of Trustees, as adopted by the AMA House of Delegates on December 6, 1988, as a valuable document; and the Society supports the AMA and the cur-

rent course it has taken and will do so as long as the AMA's position is consistent with MSNJ's position.

(3) Resolution on Surgical Assistants . . . Approved the following recommendation:

That the Executive Director of MSNJ communicate with SBME to obtain a policy statement allowing nonphysicians to be second assistants in surgery under the existing rules and regulations of the State Board.

Committee on Finance and Budget . . . Approved the following recommendations as amended:

(1) That future attendance at AMA Leadership Conferences be limited to ten members selected by the president, *in consultation with the chairman of the AMA delegation*. A predetermined stipend to be paid to each attendee for expenses. (Italics indicate amendment).

(2) That reimbursement of expenses to AMA delegates and alternates for attendance at AMA annual and interim meetings be based on a predetermined stipend per physician, per meeting.

(3) That the budget for the fiscal year, beginning June 1, 1989, and ending May 31, 1990, in the amount of \$3,949,999, with \$2,261,000 to be raised through member assessments, be adopted.

(4) That the 1990 assessment be set at \$350 per regular dues-paying member. (No change from prior year).

(5) That the 1990 assessment be set at \$60 per member for affiliate members (no longer practicing in New Jersey). (No change from prior year).

(6) That the 1990 assessment for associate members (interns-residents nonlicensed in New Jersey), and licensed residents, provided the individual is in a residency program entered

ARE YOU MOVING?

If so, please send a change of address to **NEW JERSEY MEDICINE**, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Category: (Please check one)

☐ Member, MSNJ

☐ Subscriber, NJ Medicine

☐ Other _____

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____

upon within a reasonable time after graduation from medical school, be set at \$25. (No change from prior year).

(7) That the 1989 assessment be set at \$10 per student for medical students. (No change from prior year).

Committee on Senior Citizens

... Approved the following:

That the Board of Trustees encourage at least one representative from each county to participate on the Senior Citizens Task Force, but to allow counties with more active senior citizens to have more than two representatives on the Task Force.

That the Board of Trustees encourage continued participation of leaders of various senior citizens service organizations in the activities of the Task Force.

That the Board of Trustees establish a mechanism of communication to dissident groups of senior citizens to counter any misinformation created by these groups.

Committee on Physicians' Health ... Approved the following recommendations:

That the Executive Subcommittee of the Committee on Physicians' Health be disbanded; and

That the Committee on Physicians' Health no longer has separate categories of membership. □

UMDNJ NOTES

The fiscal challenge facing UMDNJ in its advance towards national prominence was the basis for my remarks before the Assembly Appropriations Committee and Senate Revenue, Finance and Appropriations Committee last month. I specifically asked the Committees to approve the Higher Education Coalition's request to increase, by \$1.4 million, the recommended 1990 state appropriation of \$163.6 million for UMDNJ. The governor's budget reduced UMDNJ's appropriation by \$2.8 million. The Coalition's request would restore half of the reduction.

I also urged legislators to support the Coalition's total request of \$33.2 million for all of higher education.

In my testimony, I stressed that the University was well aware of the fiscal challenges facing the state and that UMDNJ itself was raising funds to finance many of its needs. For example, the University is using savings derived from a cogeneration plant to help build a new parking deck at the Newark campus.

I pointed out that UMDNJ required: 1) \$250 million to hire new faculty and staff, build physical facilities and buy equipment and supplies, all of which would support new research and clinical programs as part of UMDNJ's campaign for Top 25 status; 2) \$50 million for equipment replacement and new technology improvements at the ten-year old UMDNJ-University Hospital; 3) \$7.4 million for Newark so that the city could pay its debt for emergency medical services provided by the University; and 4) \$3 million to assist in the initial phase of construction of the Sammy Davis Jr. National Liver Institute at the University's Newark campus.

My testimony also included the following points: 1) Overall, \$650 million will be needed by UMDNJ over the next decade to achieve national prominence. The University itself will raise \$400 million of the goal—\$200 million from grants and contracts, \$150 million from increased revenues at UMDNJ-University Hospital and related health care services and \$50 million from private gifts; 2) The \$250 million we seek from the state should be considered an investment because it will allow the University to raise the other \$400 million. An initial investment in excellent physical facilities will attract far more in research grant support. We cannot entice distinguished faculty in basic and clinical sciences to leave positions at other institutions if we

cannot offer them attractive opportunities and facilities; 3) The recent findings of a national panel of experts noted that UMDNJ is well positioned to address the Top 25 challenge and possesses some of the requisites for national prominence—innovative educational programs and an excellent record in the recruitment and retention of minority students and faculty; and 4) UMDNJ-University Hospital is the only acute care hospital owned by the state. The hospital now is ten years old and has accumulated capital needs that must be addressed soon for it to continue meeting the needs not only of Newark but also of patients statewide and for it to survive as a modern, competitive entity.

I also asked legislators to support a bill sponsored by Senator Wynona Lipman (D-Essex) to appropriate \$6.5 million to Newark so the city can pay the University for providing basic and advanced life support services from fiscal year 1987 through 1989. We have borrowed from other University programs to cover this deficit. UMDNJ soon will be forced to cut existing UMDNJ-University Hospital programs and possibly even the emergency medical services itself if not reimbursed by Newark or the state.

On the subject of our quest for Top 25 prominence among the nation's health-sciences institutions, UMDNJ broke ground last month at the Piscataway campus for the \$16.5 million home of the Environmental and Occupational Health Sciences Institute (EOHSI), which we share with Rutgers University. Established in 1986, this organization already has been designated as New Jersey's first NIH center of excellence, an honor that brought with it a five-year, \$5 million grant from the National Institute of Environmental Health Sciences.

Created to explore pressing health issues related to the work

place and the environment in general, EOHSI has been housed in temporary quarters at UMDNJ and Rutgers. We expect the new 70,000-square-foot building to be completed by the summer of 1991. Features will include state-of-the-art toxicology laboratories; a resource center providing information on toxic substances; and a clinic offering medical evaluation and surveillance of people who may have been exposed to a toxic substance. A specially constructed exposure chamber will allow institute researchers to monitor the body's response to levels of pollution. □ Stanley S. Bergen, Jr, MD

NEW MEMBERS

The Medical Society of New Jersey would like to welcome the following new members:

Atlantic County

Avelino N. Cruz, MD
Edward J. Kozakowski, Jr, MD

Bergen County

Joan E. Altman, MD
Douglas G. Avella, MD
Brenda M. Christensen, MD
Paul J. Cancia, MD
Michael Denker, MD
Edward A. Ewald, MD
Zev Fainsilber, MD
Robin Y. Feigels, MD
Martin J. Frank, MD
Ruthellen Fried, MD
Zia Ghavami-Maibodi, MD
Paul R. Gliedman, MD
Warren A. Hammerschlag, MD
Iris A. Huggins, MD
Mark D. Kirschenbaum, MD
Nelly T. Loo, MD
Mark S. Mandel, MD
Janet L. Olsen, MD
Richard N. Righthand, MD
Vincent R. Saladini, Jr, MD
David N. Schwartz, MD
Andrew L. Siegel, MD
David A. Stone, MD

Burlington County

William H. Taub, MD

Camden County

John M. Bednar, MD
Katharine M. Garnier, MD

Thomas T. Hanley, MD
Anthony J. Mure, MD
David H. Sirken, DO
Sherman C. Stein, MD
Amy R. Wexler, MD

Cape May County

William R. Leisner, MD

Cumberland County

Eduardo A. Dijamco, MD

Essex County

Eric M. Bonifield, MD
Dennis R. Braun, MD
Antoinette M. Cecere, MD
Stephen E. Crane, MD
Kenneth T. DeFusco, MD
David B. DiMarco, MD
Nancy L. Elliott, MD
Philip M. Fiore, MD
Mark H. Forman, MD
Richard A. Gasalberti, MD
Sabry F. Gohara, MD
Roy A. Jurado, MD
Robert Krotenberg, MD
Sheldon I. Miller, MD
Todd A. Morrow, MD
David M. Newman, MD
Hazel A. Nurse, MD
Adeniyi A. Ogunkoya, MD
Tina M. Petillo, DO
Allen D. Rosen, MD
Stephen T. Rothbart, MD
John D. Siegal, MD
Joseph S. Sobelman, MD
Alan D. Strumeyer, MD
Ly-Le Tran, MD
Robert M. Wall, MD
Paul S. Weissman, MD
Jeffrey A. Welgoss, MD
John F. Wilson, MD

Gloucester County

Michael A. Farber, MD
Jonathan M. Winter, MD

Hudson County

Hilda R. Roque-Dieguez, MD

Hunterdon County

Tadeusz Bialy, MD
Irina I. Donev, MD
Richard B. Neches, MD

Mercer County

Terrence J. Forster, MD
William Gomez, MD
Michael A. Leopold, MD
Robert A. Martin, MD
Dennis M. Nugent, MD
Angelo R. Racaniello, MD
Cynthia L. Schaffer, DO

Ann E. Smelkinson, MD
Harvey E. Smires, Jr, MD
Ajanta S. Vinekar, MD
Richard H. Wong, MD

Middlesex County

Deborah J. Armbrust, MD
Riffat R. Chaudary, MD
Venis F. Fanous, MD
Gerald O. Fischbach, MD
Joan M. Gopin, MD
Rochelle Henner, MD
David F. Howarth, MD
Tiberiu Kovacs, MD
Malgorzata W. Kuza, MD
Peter C. Kwan, MD
Darlene J. Kwee, MD
Anthony J. Mangia, MD
Filipe D. Masquil, MD
Laura A. Micek-Galinat, MD
Ihsan A. Osman, MD
Usha R. Panicker, MD
Arvind K. Patel, MD
Krishna A. Patel, MD
Pareshchandra C. Patel, MD
David M. Rosenheck, MD
Salvatore C. Sclafani, MD
Matthew J. Shatz, MD
Geza Torok, MD
Vidya S. Vakil, MD
Thomas Westover, MD
Mona E. Yousef, MD

Monmouth County

William J. Amado, MD
Anthony DeGennaro, MD
John C. Dooley, Jr, MD
Jeffrey D. Felzenberg, MD
Denis B. Fitzgerald, MD
Lucille Folino, DO
Jeffrey D. Gould, MD
Vito M. Gulli, MD
Lawrence Katz, MD
James P. Marlys, MD
Vivienne I. Matalon, MD
Frederick J. Potulski, MD
Edward D. Stoner, MD
Ronald M. Weinberg, MD
Lewis Wetstein, MD

Morris County

Lauren M. Cooper, MD
William T. DeRosa, DO
Craig A. Dise, MD
Steven A. Haskel, MD
Harold A. Hess, MD
John A. Hurley, MD
Isaac L. Kaplan, MD
Louise D. Karger, MD
Alan M. Koenigsberg, MD
David J. Medford, MD
Steven T. Olkowski, MD

Joseph J. Ryan, MD
Celeste A. Schmucker-Karpow, MD
Nancy K. Woodruff, MD

Ocean County

John Behrman, MD
Arthur J. Greene, MD
Michael J. Marchese, MD
Felix S. Shamash, MD

Passaic County

Nicholas Alexander, MD
Cynthia G. Carzo, MD
Sessine Najjar, MD
Fortunata T. Tieng, MD

Salem County

Robert L. Breckenridge, MD
Jay L. Calesnick, MD

Somerset County

Samuel (Kuang-Zong) Chen, MD
Richard D. Colavita, MD
Cornelius T. Gallagher, MD
Richard S. Leeds, MD
Mary K. Powderly, MD
Audrey I. Prefer, MD
Bruno Schettini, MD
Jerry B. Swint, MD

Sussex County

Veneranda F. Cagande, MD
John G. O'Brien, MD

Union County

Chien-Chin Chen, MD
Michael G. Donnelly, MD
Marvin E. Friedlander, MD
Vicente F. Garcia, MD
Shelley Lanzkowsky, MD
Kerry S. LeBenger, MD
Marc M. Levine, MD
Tamara B. McCluskey, DO
Michael D. Merkin, MD
Robert J. Mich, MD
Gregory C. Oliver, MD
Sadanand S. Palekar, MD
James Perez, MD
Craig C. Price, MD
Yogesh H. Shah, MD
Therezhathu M. Thomas, MD
Manuel V. Villafranca, MD

PHYSICIAN SPECIALIST

The New Jersey State Department of Human Services, Division of Medical Assistance and Health Services (Medicaid) is looking for a physician specialist I. The position, in Trenton, requires completion of medical internship or

equivalent; licensure to practice medicine and surgery in New Jersey; three years of approved specialty training; certification or eligibility for certification by the American Board of the specialty; demonstrated competence in hospital practice; credentials committee or equivalent recommendation; approval by the Central Office Board of Professional Standards. Specific responsibilities include: involvement with fiscal agent and divisional staff in developing systems to assure proper coding and reimbursement of medical services; provide review and consultation related to claims adjudication and reimbursement; and develops medical policy/directives for publication. Please send resumes to S. Eugene Yuliano, MD, medical director, Division of Medical Assistance and Health Services, CN 712-7, Quakerbridge Plaza, Trenton, NJ 08625. □

WHAT TIME IS IT?

A watch was found at the 1989 Medical Society Annual Meeting in East Rutherford. If you misplaced your timepiece at the Sheraton Meadowlands Hotel, please contact Ms. Eileen Pfeiffer, 609/896-1766.

PLACEMENT FILE

The following physicians have written to the Executive Offices of MSNJ seeking information on opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

FAMILY PRACTICE

- Sergiusz I. Kaftal, MD, 4114 9th Ave., Brooklyn, NY 11232. Lodz (Poland) 1981. Solo, partnership, single specialty group. Available.
- Leonid Belopolsky, MD, 955 Chanticleer Dr., Cherry Hill, NJ 08003. Moscow 1961. Board certified

(ANES). Also, internal medicine. Available.

GASTROENTEROLOGY

- Robert I. Leventhal, MD, 1000 J Scaife Hall, Division of Gastroenterology, University of Pittsburgh, Pittsburgh, PA 15217. St. Georges (Grenada) 1984. Board eligible. Consultative, group, partnership, solo. Available.

INTERNAL MEDICINE

- Michael G. Donnelly, MD, 10 Overlook Rd., Apt. 4H, Summit, NJ 07901. Medical College of Pennsylvania 1987. Board eligible. Group or partnership. Available.
- Prakash J. Doshi, MD, 5676 Broadway Rd., #507, Parma, OH 44136. Bombay (India) 1984. Board eligible. Solo, partnership, group. Available.
- Lalitha B. Iyer, MD, 35 Winthrop Rd., Edison, NJ 08817. Madras (India) 1980. Board eligible. Group, partnership, emergency room. Available.
- Leonid Belopolsky, MD, 955 Chanticleer Dr., Cherry Hill, NJ 08003. Moscow 1961. Board certified (ANES). Also, family medicine. Available.
- Donald Mitrane, MD, 129 Broadway, Apt. C., Huntington Station, NY 11746. Columbia 1989. Board eligible. Group or partnership. Available.

OPHTHALMOLOGY

- Lawrence Scott Halperin, MD, 5571-D Waterman, St. Louis, MO 63112. Pennsylvania 1985. Board eligible. Group practice. Available July 1991.

ORTHOPEDICS

- D.C. Brown, MD, 2319 Sayre Dr., Princeton, NJ 08540. Available.

PEDIATRICS

- Niranjana S. Patel, MD, 2003 Valley View Dr., Pineville, LA 71360. B.J. Medical College (India) 1982. Board eligible. Also, emergency medicine. Group, hospital-based, partnership. Available.

SURGERY

- Robert A. Aldoroty, PhD, MD, 1270 Fifth Ave., New York, NY 10029-3417. Columbia 1984. Board eligible. Group or partnership. Available.

FELLOWSHIP IN CARDIAC PACING

One-year position, starting July 1, 1989. Training in pacemaker implantation, followup and electrophysiology. Requirement: completion of medical or surgical residency. Newark Beth Israel Medical Center is a 545-bed referral and teaching center featuring the largest percentage of critical care beds in New Jersey. This nationally recognized pacemaker center does over 200 implants per year.

Write to:

Victor Parsonnet, M.D.
Director of Surgery
Newark Beth Israel Medical Center
201 Lyons Avenue
Newark, New Jersey 07112

12TH ANNUAL CURRENT CONCERNS IN ADOLESCENT MEDICINE— "A Practical Approach To Current Problems In Adolescents"

October 5 and 6, 1989, The Grand Hyatt Hotel, New York, NY. Sponsored by: Division of Adolescent Medicine, Schneider Children's Hospital of Long Island Jewish Medical Center, New Hyde Park, NY. Topics include: Depression and Suicide; Sexuality; Aids; Cardiac Sudden Death; Substance Abuse; Eating Disorders; Controversies in Cholesterol; Therapeutic Diets and more. Credits: 12 Category 1 from the ACCME and AMA. Information: Ann J. Boehme, Associate Director for Continuing Education, Schneider Children's Hospital of Long Island Jewish Medical Center, New Hyde Park, NY 11042; (718) 470-8650.



ANNUAL CME ASSEMBLY

presented by the

MEDICAL SOCIETY OF THE
STATE OF NEW YORK

CASE MANAGEMENT AND CLINICAL CARE DILEMMAS

SEPTEMBER 15-16, 1989

THE NEW YORK HILTON, NEW YORK CITY

HIGHLIGHTS ...

24 CME Sessions: Panel Discussions: Technical Exhibits, Hospitality Breaks include Coffee Service, Cocktail/Reception, (Friday), Continental Breakfast, Buffet Luncheon, (Saturday).

Registration: A \$25 fee for members of the New Jersey State Medical Society; no fee for residents, medical students, or medical assistants. Non-member physicians—\$50; Allied Professions \$10. We are accredited by the Accreditation Council for CME.

For a copy of the preliminary program contact:
MSSNY, Dept. of Meetings Management
420 Lakeville Road,
P.O. Box 5404, Lake Success, N.Y. 11042.
(516) 488-6100



SPORTS MEDICINE: PROTECTING THE YOUNG ATHLETE FRIDAY, NOVEMBER 3, 1989

In view of the major role that participation in sports plays in the daily lives of Americans, we offer a one-day symposium for physicians, sports trainers, and coaches. Because of the real potential for any youngster to sustain a severe and even life threatening injury, it is essential for educators and supervisors of young athletes to know that correct initial or immediate treatment is available at the scene well before traditional care can be initiated.

FEE: \$30 6 AMA Category I credit hours

For further information:
NYU Post-Graduate Medical School
550 First Ave., New York, N.Y. 10016
(212) 340-5295

NJM6/89

MONDAY-FRIDAY OCTOBER 16-20, 1989 FIVE DAY EMERGENCY MEDICINE BOARD REVIEW COURSE



Bellevue Hospital Center
Emergency Services

An intensive, five-day course providing:

- a concentrated review and update of Emergency Medicine topics
- analysis of relevant articles from the past six years of Emergency Medicine literature
- interaction regarding clinical controversies in management techniques
- sessions in written test-taking, and oral problem solving in ED medicine
- group sessions to assist participants with Oral Board preparation
- review of sample multiple choice questions with emphasis on test taking techniques
- special opportunity for 1 on 1 sessions with Board certified faculty to be provided on an ongoing basis throughout the course

TUITION: \$700

ACCREDITATION: 38 AMA Category I credit hours/
ACEP pending

For further information:
NYU Post-Graduate Medical School,
550 First Avenue, N.Y. 10016 (212) 340-5295

NJM6/89

CONTINUING EDUCATION

Contact the sponsoring organization (indicated in italics) for further information concerning these continuing medical education courses. *NEW JERSEY MEDICINE* does not take responsibility for last minute cancellations or changes in programs.

DERMATOLOGY

July

- 7 **Principles of Dermatological Therapy**
9-10 A.M.—St. Francis Medical Center, Trenton
(*AMNJ*)

INFECTIOUS DISEASES

July

- 11 **Counseling and Testing for HIV Infection**
9-10 A.M.—Holy Name Hospital, Teaneck
(*AMNJ and NJDOH*)
- 13 **Counseling and Testing for HIV Infection**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(*AMNJ and NJDOH*)
- 21 **Counseling and Testing for HIV Infection**
8:30-9:30 A.M.—United Hospitals Medical Center, Newark
(*AMNJ and NJDOH*)

MEDICINE

July

- 5 **What the Primary Physician**

Must Know and Do To Save Diabetic Legs

11 A.M.-12 Noon—Morristown Memorial Hospital, Morristown
(*AMNJ and NJDOH*)

13 The Renal Effects of NSAID

12 Noon-1 P.M.—Community Medical Center, Toms River
(*AMNJ and Community Medical Center*)

August

- 17 **Medical and Psychiatric Aspects of Drug and Alcohol Abuse**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(*AMNJ*)

ORTHOPEDICS

August

- 10 **Nonoperative Management of Chronic Back Pain**
2-3 P.M.—John E. Runnells Hospital, Berkeley Heights
(*AMNJ*)

PSYCHIATRY

July

- 6 **Seasonal Depression**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 13 **The Return of the Forensic Patient to Society**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

20 AIDS: Managing the Psychosocial Impact

12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

August

- 3 **Topographic Brain Mapping and Electrodiagnosis**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 10 **CT Scan Studies in Teenagers with Schizophrenia**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 15 **Issues in the Treatment of Anxiety: Drug Dependence and Abuse**
7:30-8:30 A.M.—Mercer Medical Center, Trenton
(*AMNJ and Mercer Medical Center*)
- 17 **Adolescent Health Issues**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)
- 31 **The Neuropsychiatric Aspects of AIDS**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

UROLOGY

July

- 19 **Urinary Tract Infections**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(*AMNJ*)
- 22 **Clinical Cases Presentation**
6:30-7 P.M.—Robert Wood Johnson Medical School, New Brunswick
(*UMDNJ*)

August

- 24 **Clinical Cases Presentation**
6:30-7 P.M.—Robert Wood Johnson Medical School, New Brunswick
(*UMDNJ*)

Continuing Medical Education Listings. Please send all listings to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648. Listings are printed in two issues, and used as space permits. For additional information, contact MSNJ or the Academy of Medicine of New Jersey.

IN MEMORIAM

John J. Clark. Retired pediatrician John James Clark, MD, died on December 5, 1988. Born in 1914 in DePere, Wisconsin, Dr. Clark received his medical degree at the University of Kansas School of Medicine, in 1941. Awarded his New Jersey medical license in 1949, Dr. Clark practiced in Long Branch for 35 years, retiring in 1984. During World War II, he served as a major in the U.S. Army medical corps. He was a member of our Monmouth County component for many years.

Jean G. Dupuy. Retired internal medicine specialist Jean Gabriel Dupuy, MD, died on December 20, 1988, at the age of 89. A native of France, Dr. Dupuy attended the Faculty of Medicine at the University of Paris, graduating with his medical degree in 1925. After emigrating to the United States, Dr. Dupuy began affiliations with three hospitals in Elizabeth: St. Elizabeth Hospital, Alexian Brothers Hospital, and Elizabeth General Medical Center. He was a member of our Union County component and of the AMA. In 1975, Dr. Dupuy received the Medical Society of New Jersey's Golden Merit Award.

Edward Foord. Gynecologist Edward Foord, MD, died on December 14, 1988, at the age of 65. A native of Torrington, Connecticut, Dr. Foord received his medical degree at Yale University School of Medicine, New Haven, Connecticut, in 1947. In 1953, he opened an obstetrics and gynecology practice in Burlington, retiring in 1986. Af-

filiated with Memorial Hospital of Burlington County, Dr. Foord was chief of the Department of Obstetrics, chief of staff, and associate director of medical education. A member of our Burlington County component and of the AMA, a diplomate in obstetrics and gynecology as well as a fellow of the American College of Obstetricians and Gynecologists, Dr. Foord was a teacher of residents at Hahnemann School of Medicine, Philadelphia. Active in the Medical Society of New Jersey, Dr. Foord was vice-speaker for the House of Delegates, chairman of the maternal and infant welfare committee, and served on the Council on Public Relations of the Medical Society.

M.J. Friedman. A family physician in Holmdel for over 25 years, Myron John Friedman, MD, died on October 20, 1988, at the age of 73. A native of France, Dr. Friedman came to the United States in 1950, after attending Sorbonne Medical School, University of Paris, and earning his medical degree. During World War II, he was a colonel in the French army, and was awarded the Croix de Guerre. In 1961, he obtained a New Jersey license to practice medicine. A member of our Monmouth County component, Dr. Friedman was affiliated with Riverview Medical Center, Red Bank.

Jose A. Hipolito. Jose Anselmo Hipolito, MD, chief of anesthesiology at Newcomb Medical Center, Vineland, died at the age of 49 on October 27, 1988. Dr. Hipolito

received his degree from the University of Santo Tomas, Manila, in 1968; he was licensed to practice medicine in New Jersey in 1975. A member of our Cumberland County component and of the AMA, Dr. Hipolito was a diplomate of the American Board of Anesthesia.

David W. Jones. David Walton Jones, MD, a semi-retired family physician specializing in skin and venereal disease, died recently. Born in Shreveport, Louisiana, Dr. Jones received his medical degree at Ohio State University College of Medicine, Columbus, Ohio, in 1941. In addition to an East Orange practice, Dr. Jones maintained affiliations with Newark Beth Israel Medical Center, and Presbyterian Hospital, both in Newark. He was a U.S. Army major from 1953 to 1954. Dr. Jones was a member of our Essex County component and of the American Medical Association.

Benjamin E. Smith. Occupational medicine and surgery specialist Benjamin Earl Smith, MD, died on December 16, 1988, at the age of 72, after retiring in 1987. A lifelong Trenton area resident, Dr. Smith received his medical degree at the University of Pennsylvania School of Medicine, Philadelphia, in 1941. Dr. Smith had a private family practice on Greenwood Avenue and was medical director for the Trenton District of the U.S. Postal Service. During World War II, he served as a captain in the U.S. Army medical corps. Dr. Smith was a member of our Mercer County component.

EDITORIAL CRITERIA

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. All material published is copyrighted by MSNJ.

Content. The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevant to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made to an audience in New Jersey.

Assignment of Copyright. In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statement accompany-

ing material offered to *NEW JERSEY MEDICINE* must contain the following language and must be signed by all authors.

"In consideration of *NEW JERSEY MEDICINE* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *NEW JERSEY MEDICINE*.

Specifications. Submit two manuscripts that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods should be identified.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 30-word abstract.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission must be submitted.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

References should not exceed 35 citations except in review articles, and should be cited consecutively by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in numerical order. The style of *NEW JERSEY MEDICINE* is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

Publication Policy. Receipt of each manuscript will be acknowledged; the paper will be referred to the Editorial Board. The final decision is reserved for the editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. Galley proofs will be submitted to the author for correction.

Reprint Orders. Reprints may be ordered after the author is notified that the article has been selected for a specific issue. A check for the cost of reprints must accompany that order.

Communications. All communications should be sent to the editor, *NEW JERSEY MEDICINE*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

THE NATIONAL LIBRARY OF MEDICINE

1988 CORPORATE PATRONS

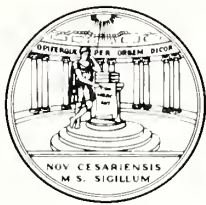
American Hospital Association
American Medical Association
Cambridge Information Group
E.I. du Pont de Nemours & Co.
Eastman Kodak Company
Eli Lilly and Company
Hoffmann-La Roche Inc.
Johnson & Johnson
Merck & Company, Inc.
Provident Life & Accident
Schering-Plough Corporation
Sterling Drug, Inc.
Sutton Communications, Inc.
Technicon Instruments Corp.
The Upjohn Company
Warner-Lambert Company
Whitehead Associates

gratefully
acknowledges
the contributions
of the following
companies and
organizations
as patron
members of
the Friends of
The National
Library of
Medicine



Friends of the NLM
424 C Street, N.E.
Washington, D.C. 20002

**"The more you know,
the better you heal"**



MSNJ NEWSLETTER

SPECIAL ASSESSMENT

The Society was sued by Doctor Celestino Clemente regarding his being omitted from the *Membership Directory* because of delinquency regarding the special assessment. Injunctive relief was sought. MSNJ opposed the injunction. Mr. Kern represented MSNJ. At this point, the suit has been withdrawn.

SPECIAL REPORT TO THE MEMBERSHIP

Meeting with Pennsylvania Blue Shield and HCFA (Region III), May 23, 1989, Medicare Transition

Mr. Joseph Lucci and Mr. Vincent Maressa met with Pennsylvania Blue Shield and HCFA personnel and discussed the following issues:

1. **Consultations Followed by Procedures.** In a memorandum dated April 20, 1989, the Regional Office approved separate reimbursement for preprocedural consultations and preoperative medical visits. All claims impacted by this issue have been paid. Medical policy bulletins currently are being revised to reflect these revised guidelines and will be distributed.

2. **Peritoneal Dialysis Services.** HCFA has advised PBS to follow the Prudential format which was the national policy. This directive was sent on April 17, 1989. All pending claims have been processed. Medical policy is being revised to demonstrate these changes. The coding problems have been resolved. Pricing format is being resolved, and a HCFA specialist will visit Camp Hill within ten days to complete this transaction.

3. **Mohs' Chemosurgery.** Because of profile inequities, PBS has initiated systems changes to remove Mohs' chemosurgery procedure codes from multiple surgery guidelines. In the interim, these claims will be manually priced. Further, New Jersey physicians must be educated to bill the full charge and allow the system to reduce accordingly for multiple surgery.

4. **Electromyography.** Pennsylvania Blue Shield reimbursement is done on a 2.3 to 3 nerve code, while Prudential used a 1 nerve format. The result was reduction in payments. PBS will increase prevailing amounts for procedure codes W-9591-W-9549. These changes were effective May 21, 1989.

5. **Radiology Concerns.** A congressionally mandated 40 percent payment limitation went into effect on April 1, 1989. The Radiology Society has been working closely with Pennsylvania Blue Shield on this issue. Two hundred fifty codes have been deleted from the list, and final settlement is being worked out between PBS and the Radiology Society through John Fanburg, Esq.

6. **Assistants at Surgery.** Differences have been noted between Prudential and Pennsylvania Blue Shield on policies regarding assistants at surgery. PBS policy has been reviewed, and will conform to the major surgery rule except for routine hernia, routine appendectomy, and varicose veins. PBS will compensate for complex hernia and complex appendectomy. We requested further consideration. HCFA has referred this issue to a policy specialist for further study.

7. **Same Patient, Same Stay, Same Surgeon, Different Surgeries.** Unrelated procedures done at different times will be compensated separately, and will be manually processed. It will not follow the pattern of a denial followed by an appeal, as previously was experienced.

8. **ICD-9-CM.** The diagnostic coding requirement will be implemented on July 1 by Congressional act. During the current monitoring period, 40 percent of the New Jersey claims do not comply. PBS and HCFA are concerned with this failure ratio, which is significantly higher than any other state within the region. We suggested a clear explanation be sent to all physicians promptly, along with appropriate examples. This will be done along with a separate mailing from HCFA to component societies.

9. **Basic Processing.** While mail and telephone lines are clogged, processing has improved. Each month, 1.3 million claims are being paid. HCFA has set an 18-day standard from initial transmittal to payment as the benchmark. The MSNJ files which were at 175 on April 17 have been reduced dramatically. We now have about 100, and that incorporates all new files.

REPORT OF THE BOARD OF TRUSTEES OF THE AMA TO THE HOUSE OF DELEGATES JUNE 1989: MEDICAL ETHICS

No single matter is more important to the medical profession than maintaining and observing a code of ethics. It is by "professing" to be devoted to the high moral good of healing the sick—as expressed in the principles and self-imposed restrictions of a code of ethical conduct—that medicine has established its unique professional standing. As Professor Leon Kass, MD, has said: "Being a professional is thus more than being a technician. It is rooted in our moral nature; it is a matter not only of the mind and hand but also of the heart, not only of intellect and skill but also of character. For it is only as a being willing and able to devote himself to others and to serve some high good that a person makes a public profession of his way of life."

Increasingly, physicians need guidance on the ethics of medicine. Increasingly, the government and the public need to be reassured that physicians maintain their patients' interests above their own. As the practice of medicine becomes more complex technologically and economically, the physician more frequently faces moral quandaries. Which patients should receive the limited number of organ transplants? How should a physician balance his devotion to the patient's best interests with society's need to restrain health care costs? When is it permissible for a physician to withhold life-prolonging medical care from a hopelessly ill patient?

At least since Hippocrates, the medical profession has attempted to maintain a uniform code of conduct. At the first official meeting of the AMA in 1847, the two principal items of business were the establishment of a code of ethics and the creation of minimum requirements of medical education and training. In 1858, a Committee on Ethics, now the Council on Ethical and Judicial Affairs, was appointed to implement the ethics code. In the ensuing decades, generations of physicians have worked to refine and reformulate the code as counseled by experience and the temper of the times. Today, a majority of states have enacted AMA's code as the standard for ethical professional conduct.

The cornerstone of the AMA's code of ethics is found in the *Principles of Medical Ethics*. The *Principles* recognize the physician's responsibilities to patients, the profession, and society generally, and they define the essentials of honorable behavior for physicians. Elaboration of the *Principles* in opinions and reports on specific ethical questions by the Council on Ethical and Judicial Affairs has resulted in the only comprehensive code of medical ethics in existence.

The code has provided physicians with guidance on the full range of ethical questions, from genetic engineering to confidentiality of medical records to investments in health care facilities, and has often pioneered in the progression of ethical thought. In 1868, for example, the AMA urged that women be entitled to practice medicine. Five years later, the United States Supreme Court was still permitting states to prohibit women from practicing medicine and law, and it was not until 1920 that women were guaranteed the right to vote. More recently, the AMA has issued pathbreaking opinions on the physician's obligation to treat patients with AIDS and on the patient's right to refuse life support when terminally ill. These opinions and others have been cited in scores of court decisions and congressional debates.

To ensure that physicians are prepared to meet the challenges and demands in medical ethics, the Council on Ethical and Judicial Affairs and the Office of General Counsel have begun new efforts to provide appropriate guidance:

1. The AMA will tighten the educational and enforcement mechanisms for the Council's opinions by establishing a network of support for the grievance and ethics committees of all county, state, and specialty societies. The Council's opinions and reports will be distributed directly to those committees upon release, their perspectives and concerns will be formally and regularly solicited, support and protection for their activities will be provided. At this meeting of the House of Delegates, a guidebook on the proper and effective handling of complaints about unethical behavior is being distributed.

2. The Federal Trade Commission and the Justice Department have indicated their support for self-regulation, including appropriate enforcement of the AMA's ethical guidelines, and the AMA believes it can obtain from those agencies formal acceptance of more effective mechanisms for such enforcement.

3. For most physicians, the opinions and reports of the Council will be self-enforcing—physicians need only know the parameters of ethical behavior and they will comply. But physicians too frequently do not know the rules, and many principles of medical ethics cannot be derived by instinct. Therefore, through the enhanced Federation education network, the AMA will institute a variety of mechanisms to improve physicians' knowledge of the requirements of ethical conduct.

- a. Every new AMA member will receive the *Principles* and the Council's *Current Opinions*, and upon request, any AMA member will be sent them free of charge.

b. Approximately, 10,000 copies of the 1989 edition of the *Principles and Current Opinions* will be distributed to the House of Delegates, AMA Councils and advisory bodies, the Federation, libraries, medical schools, state medical boards, bioethics institutes, federal and state governments, and the media.

c. For the first time, the indepth report of the Council will be published in a looseleaf volume and new reports will be published and distributed in a compatible format.

d. A regular commentary in *JAMA* will discuss ethics issues in a timely fashion, and a regular column in *AMNews* will respond to specific issues in a question-and-answer format. Other media efforts will be undertaken under the guidance of the Public Information Office to focus greater attention on the opinions and reports of the Council on Ethical and Judicial Affairs.

e. The Council will develop a handbook for medical students and residents that can be used as a guide for clinical decision making on ethical issues. A series of videotapes will be produced for use in medical school classrooms as a primer on medical ethics.

4. An Ethics Advisory Task Force has been formed with staff representatives from the Councils on Ethical and Judicial Affairs, Science and Technology, Legislation, and Medical Services to develop major projects that cut across the different substantive areas.

5. The Council will create a guide for patients and the public which describes the elements of an ethical physician-patient relationship. From ancient times, physicians have recognized that patient involvement and trust are essential elements of the healing process, that medical care is a collaborative effort between physician and patient. Before patients can be expected to assume their share of responsibility in the physician-patient relationship, they must be assured that their fundamental needs will be met. These needs include information about their care and its cost, disclosure of conflicts of interest, courtesy and responsiveness, confidentiality, the provision of essential care, and continuity of care.

Conclusion. There is great need today for continuing leadership by physicians in defining and maintaining their code of ethical conduct. The *Principles of Medical Ethics* and *Current Opinions* of the Council on Ethical and Judicial Affairs of the AMA provide the profession's only comprehensive code of professional conduct—and that is how it should be. Practicing physicians, through their professional organizations, heeding the concerns of public officials, their patients, and others, have the right and duty to determine the standard of conduct of their profession. In this report, the AMA again commits itself to making that right and duty its highest priority.

PANIC ATTACKS

If you suffer from panic attacks, you may be eligible to be a part of a new research study. Physical examination, laboratory tests, physician visits, and medication will be free of charge. Please contact Hugh Smith, Carrier Foundation, at 201/874-4000, ext. 4396. Bradley D. Evans, MD, and Helen M. Pettinati, PhD, will supervise the study.

CDS REGULATIONS

The Health Department has proposed regulations to alter recordkeeping and dispensing and prescription requirements for schedules II, III, and IV. These have been distributed to county and specialty societies for comment. Initial staff review indicates the proposal is reasonable.

PHYSICIANS' HEALTH PROGRAM

The Society successfully defended a motion by a plaintiff's attorney to gain access to certain treatment records. Mr. Conroy of Kern and Augustine represented MSNJ.

CME IN NEW JERSEY

In September, *NEW JERSEY MEDICINE* will be presenting a special issue on continuing medical education in New Jersey. The purpose of this publication will be to highlight various aspects of continuing medical education as it pertains to New Jersey practitioners. Topics to be included are education and computers, the history of the Academy of Medicine of New Jersey, groups that influence CME in New Jersey, new trends for continuing education, hospitals and CME, the relationship between MSNJ and AMNJ; the need for continuing education for physicians, the value of CME, and continuing education and television. The guest editors for this special edition will be Alan J. Lippman, MD, and James Thorpe, MD. Issues will be sent to all members of the Society; additional copies are available for \$5 from Society headquarters, Two Princess Road, Lawrenceville, NJ 08648. □

THE STRUGGLE FOR INDEPENDENCE ISN'T ALWAYS FOUGHT IN SOME FAR-OFF COUNTRY.

*At Bryn Mawr Rehabilitation Hospital
We Face The Battle Everyday...
And We're Winning.*

Over the last ten years, the Bryn Mawr Brain Injury System has made great strides working closely with physicians, nurses and therapists to provide cognitively challenged patients with a vehicle for independence.

By mapping out a carefully planned strategy and implementing our renowned continuum of care, BMRH maximizes an individual's potential by starting at the beginning from the most basic levels of rehabilitation to re-entry into the community. BMRH's professionals are dedicated to helping brain injury patients win ground in the battle they must fight.

Ten years of successfully fighting for our patients' independence has given us the experience and insight to see a future that promises exciting advancements in brain injury rehabilitation.

Complete information on the
Bryn Mawr Brain Injury System
is now available.

Contact the Public Relations Office at
(215)251-5401.



***BRYN MAWR REHABILITATION HOSPITAL
414 PAOLI PIKE, MALVERN, PA 19355***

Legislative Update

MSNJ Positions on Current Legislation

Bill	Subject	MSNJ Position	Committee	Present Status
S-219 O'Connor	Provides for the licensing and regulation of nutritionists through a Board of Nutrition within the Department of Law and Public Safety.	Active Opposition	Senate: LIP	In committee
S-263 Dumont	Provides for a three-year statute of limitations, except for fraud, intentional concealment, or nontherapeutic or diagnostic purpose. Minors would have until age 11 on any injury prior to age 8.	Active Support	Senate: JUD	In committee
S-470 Bubba	Requires physicians to personally present and obtain surgical consent forms and signatures. The form shall state the name of any assisting physician that performs surgery under the supervision of the attending.	Active Opposition	Senate: LIP	In committee
S-718 Codey	Amends the certificate of need to include physicians whenever a health service has been regionalized by regulation of the Department of Health. Regulation would terminate within three years, at which time, the commissioner could readopt the regulation.	Active Opposition	Senate: IHW	In committee
S-784 McManimon	Allows psychologists to certify disability.	Active Opposition	Senate: LIP	Passed in Senate; in Assembly committee (L)
S-882 Jackman	Amends existing law to make certain that dentists acting as independent contractors are not subject to unemployment and disability taxes.	Active Support	Senate: LIP	In committee
S-1018 Lipman	Authorizes nurses to practice medicine and to prescribe drugs and devices.	Active Opposition	Senate: LIP	In committee
S-1062 DiFrancesco	Requires every person who has reasonable cause to believe an elderly or disabled person is the victim of abuse or exploitation to report that information to the commissioner of human services or his designee.	Active Support	Senate: IHW	In committee
S-1123 Cardinale	Exempts the private practice of medicine from the certificate of need law.	Active Support	Senate: IHW	In committee
S-1146 Cardinale	Limits noneconomic damage awards to \$100,000.	Active Support	Senate: JUD	In committee
S-1153 Cardinale	Requires that alcoholic beverages be labeled to advise pregnant women of potential harm to fetus when consumed.	Active Support	Senate: IHW	In committee
S-1188 Feldman	Provides that within 60 days of filing an action against a physician, the plaintiff must provide	Active Support	Senate: JUD	In committee

LEGISLATIVE UPDATE

Bill	Subject	MSNJ Position	Committee	Present Status
	an affidavit from an expert that there has been a negligent deviation from the accepted standards of practice.			
S-1205 Feldman	Makes the decision of an administrative law judge final in contested agency actions.	Active Support	Senate: JUD	In committee
S-1208 Feldman	This bill would establish and license two categories of social workers and would create a Board of Social Work Examiners in the Department of Law and Public Safety whose powers and duties, among others, would be to administer the act, examine and license candidates for the various categories of social work, and promulgate rules and regulations necessary for the effective enforcement of the act. The two categories of licensed social work would be (1) social work specialist, who would be required to have a doctorate in social work or a master's degree from an accredited school of social work and (2) social workers who would need a baccalaureate degree from an accredited college or university social work or social welfare program. The bill would "grandfather" in all persons currently in practice, provided they have been in practice in one of the two licensed categories for two of the last five years, and apply to be licensed within 180 days from the effective date of this act.	Active Opposition	Senate: IHW	Passed in Senate; in Assembly committee (HERP)
S-1252 Contillo	Provides for a nonbinding referendum concerning the enactment of a national health plan.	Active Opposition	Senate: IHW	Passed in Senate; in Assembly committee (HHR)
S-1491 Gagliano	Prohibits the licensing and/or practice of physician assistants.	Active Support	Senate: IHW	In committee
S-1541 Pallone	Requires food and hydration to be provided to all patients regardless of consent; does not provide immunity to health professionals nor is a penalty for nonobservance provided.	Active Opposition	Senate: IHW	In committee

Senate Reference Committees

LIP: Labor, Industry, and Professions
 SGF&IR&VA: State Government, Federal & Interstate Relations & Veterans Affairs
 IHW: Institutions, Health & Welfare
 JUD: Judiciary
 RFA: Revenue, Finance & Appropriations
 CH: Children Services
 LPSD: Law, Public Safety, and Defense

Assembly Reference Committees

HHR: Health and Human Resources
 HERP: Higher Education and Regulated Professions
 JUD: Judiciary
 SG: State Government
 INS: Insurance
 SC: Senior Citizens
 EDA: Economic Development and Agriculture
 L: Labor
 IA: Independent Authorities

LEGISLATIVE UPDATE

Bill	Subject	MSNJ Position	Committee	Present Status
S-1649 Orechio	Requires health care licensees to accept Medicare determination of their fees.	Active Opposition	Senate: IHW	In committee
S-1705 Bassano	Eliminates joint and several liability.	Active Support	Senate: JUD	In committee
S-1845 Lesniak	Provides for structured payments in civil actions against health care providers when future damages exceed \$250,000. An annuity contract must be offered to guarantee the future payments.	Active Support	Senate: JUD	In committee
S-2509 Lynch	Provides that physicians, chiropractors, and podiatrists may not use unlicensed aides to provide physical modalities.	Active Opposition	Senate: LIP	In committee
S-2592 DiFrancesco	Provides for the licensing and regulation of occupational therapy.	Active Opposition	Senate: LIP	In committee
S-2636 Brown	Expands the jurisdiction of the state ombudsman to acute care hospitals.	Active Opposition	Senate: RFA	Out of committee; 2nd reading
S-2673 Lesniak	Provides that officers and directors are immune from suits by members and shareholders when acting in good faith unless there is a material conflict of interest.	Active Support		Signed into law as c.17, P.L. 1989
S-2936 Codey	The Professional Medical Conduct Reform Act of 1988.	Active Support	Senate: IHW	Out of committee; amended; 2nd reading
A-88 Villane	This bill would establish and license two categories of social workers and would create a Board of Social Work Examiners in the Department of Law and Public Safety whose powers and duties, among others, would be to administer the act, examine and license candidates for the various categories of social work, and promulgate rules and regulations necessary for the effective enforcement of the act. The two categories of licensed social work would be (1) social work specialists, who would be required to have a doctorate in social work or a master's degree from an accredited school of social work and (2) social workers who would need a baccalaureate degree from an accredited college or university social work or social welfare program. The bill would grandfather in all persons currently in practice, provided they have been in practice in one of the two licensed categories for two of the last five years and apply to be licensed within 180 days from the effective date of this act.	Active Opposition	Assembly: HERP	In committee
A-148 Penn	Permits psychologists to certify disability under the temporary disability benefits law.	Active Opposition	Assembly: L	In committee

LEGISLATIVE UPDATE

Bill	Subject	MSNJ Position	Committee	Present Status
A-267 Felice	Prohibits institutions from operating retail pharmacies within 1,500 feet of their facility.	Active Opposition	Assembly: HHR	Passed in Assembly; in Senate committee (IHW)
A-420 Deverin	Creates a new class of licensed practitioners who would function independently and would be permitted to perform such services as the design, fabrication, and application of splints, sensorimotor activities, the use of specifically designed crafts, guidance in the selection and use of adaptive equipment, therapeutic activities to enhance functional performance; prevocational evaluation and training, and consultation concerning the adoption of physical environments for the handicapped. The State Board of Medical Examiners will exercise jurisdiction.	Active Opposition	Assembly: HERP	In committee
A-470 Colburn	Creates a commission to study the effects of the DRG program and the rate-setting system in New Jersey on services provided in acute care hospitals.	Active Support	Assembly: HHR	Passed in Senate; amended; in Assembly committee
A-479 Colburn	Provides that the costs associated with nursing services must be specifically identified in hospital budgets and rating formulas.	Active Support	Assembly: HHR	In committee
A-886 Kern	Increases the penalties for using false credentials to obtain a license or to represent oneself as licensed.	Active Support	Assembly: HERP	Out of committee; 2nd reading
A-1082 Moran	Establishes a public blacklist to be compiled by the Division of Aging on those physicians whose fees exceed Medicare allowances.	Active Opposition	Assembly: HHR	In committee
A-1532 Doria	Creates a licensing board for chiropractic. Transfers all functions and responsibilities of the State Board of Medical Examiners regarding chiropractic to the new board. Removes the place for a chiropractor from the medical board.	Active Opposition	Assembly: HERP	In committee
A-1538 Doria	Requires that all closed professional liability claims be reported to the Department of Insurance.	Active Opposition	Assembly: INS	In committee
A-1542 Doria	Permits dentists who have had their credentials approved to practice in hospitals.	Active Opposition		Signed into law as c.147, P.L. 1988
A-1544 Doria	Allows HMO beneficiaries free choice of provider. Limits HMO liability to its established fee schedules. In the case of capitation or salaried plans, the Medicaid fee schedule would be used.	Active Support	Assembly: HHR	In committee
A-1591 Bennett	Requires statutory authorization for the licensure or certification of health care practitioners.	Active Support	Assembly: HHR	Passed in Assembly; in Senate committee (IHW)

LEGISLATIVE UPDATE

Bill	Subject	MSNJ Position	Committee	Present Status
A-1600 Kelly	Allows nurses who practice in collaboration with physicians to prescribe medications in accordance with protocols submitted to and approved by the State Board of Nursing.	Active Opposition	Assembly: HHR	In committee
A-1884 Zecker	Permits certain nonprofit corporations to extend immunity to trustees, directors, officers, members, or employees when exercising judgment or discretion.	Active Support	Assembly: INS	In committee
A-1898 Miller	Establishes a 3-year statute of limitations in tort actions against health care providers. Children would have until age 11 to bring an action for injuries prior to age 8. After age 8 they come under the 3-year standard. Fraud, concealment, and unintentional foreign bodies "toll" the statute.	Active Support	Assembly: INS	In committee
A-1899 Miller	Provides that within 60 days of filing a medical malpractice complaint, the plaintiff must supply an affidavit, by a qualified expert, that reasonable cause exists to believe malpractice occurred.	Active Support	Assembly: INS	In committee
A-1969 Girgenti	Provides for structured settlements when future damages exceed \$150,000.	Active Support	Assembly: INS	In committee
A-2305 Karcher	Requires health practitioners to accept Medicare assignments.	Active Opposition	Assembly: HHR	In committee
A-3166 Improveduto	Provides physicians, chiropractors, and podiatrists may not employ unlicensed aides to administer physical modalities.	Active Opposition	Assembly: HHR	In committee
A-3271 Shusted	Creates a system for training and certifying dialysis technicians.	Active Support	Assembly: HERP	Passed in Assembly; in Senate committee (LIP)
A-3296 Zangari	Provides that chiropractor services are included in the definition of medical services under worker's compensation. (Chiropractic services have been included under worker's compensation allowances for over 20 years.)	Active Opposition	Assembly: HERP	Passed in Assembly; in Senate committee (LPSD)
A-3468 Loveys	Permits the governor to substitute chiropractors for dentists or physicians on the Medical Advisory Council.	Active Opposition	Assembly: IA	Out of committee; 2nd reading
A-4045 Colburn	Extends Medicaid coverage to certain pregnant women and children under one year (family income is 185 percent of federal poverty level); children up to five years of age if family income is 100 percent of federal poverty level.	Active Support		2nd reading
A-4046 Shusted	Provides for structured payments in civil actions against health care providers when future damages exceed \$250,000. An annuity contract must be offered to guarantee the future payments.	Active Support	Assembly: INS	In committee

**“A fee-for-service insurance program
with complete office coverage?”**



**I don't
believe it.”**



CAPITOL COMMENTARY

MEDICAL WASTE UNDER WRAPS?

The fanfare in Washington and Trenton was tremendous. The message was clear: no more syringes, intravenous bags, and blood vials on the beaches. The new federal and state medical waste laws promised intensive monitoring, swift prosecution of violators and harsh penalties.

So what is happening with medical waste? At this date, not very much—at least from the viewpoint of physicians, hospitals, and other “generators” who are obligated to comply with the new laws.

Neither level of government, as of late June, was able to implement the two key elements of the program: telling doctors who can haul the waste, and where it goes. Until that is settled, there really is no program.

New Jersey's law technically became effective the day it was signed last March. The federal law took effect on June 22. They nearly are identical; both require physicians, dentists, podiatrists, and others to separate medical waste from ordinary office trash, and make sure it is picked up by an approved hauler. The major difference is that the federal law would have “small generators” (less than 220 pounds per month) keep logs of their medical waste, while the state law (which takes precedence) requires them to fill out a manifest, similar to a Federal Express form.

Nevertheless, the laws are in effect, and we suggest that physicians contact the federal EPA or the state DEP from time to time to find out what is happening. Here are the numbers: Environmental Protection Agency, 1/800/424-9346 or 1/212/264-8357 (ask for George Meyer); and Department of Environmental Protection, 1/609/984-7840 (ask for Bob Confer).

RETURN OF THE SURCHARGE

Insurance Commissioner Merin's proposed malpractice insurance surcharge has been revived with the publication of a “reproposed” regulation in the June 19, 1989, *New Jersey Register*. The document adopts the recommendations of hearing officer Holly Bakke, who conducted last October's public hearing on the issue.

This version would have physicians who did not purchase insurance from the state's defunct Medical Malpractice Reinsurance Association pay a 2.5 percent surcharge over eight years to help retire the program's \$65 million debt. Physicians who purchased the cut-rate insurance would be surcharged 5 percent. Likewise, hospitals which bought the state insurance would be surcharged 3.35 percent, and hospitals which did not, 2.5 percent.

It is beginning to look like the Insurance Department is taking its cue from Hollywood's practice of churning out endless sequels to horror movies. The surcharge on innocent physicians started at 4 percent, then became 5 percent, now it's 2.5 percent. Nightmare on State Street, Part III? In the end, if the rule is adopted, we believe we have the legal ammunition to kill the surcharge. □

When it comes to your patients' health leave no stone unturned.



Lithotripsy at The New Jersey Kidney Stone Treatment Center can be the alternative.

Convenience—The New Jersey Kidney Stone Treatment Center is centrally located in downtown New Brunswick, near major highways, for easy access for you and your patients.

Flexible scheduling—The Center offers scheduling with no delay. In most cases, your patient can be treated within a week of your call. Our extended hours allow you to make appointments at the convenience of both you and your patients.

Bath-free equipment—The Center is equipped with the most advanced Dornier HM4 lithotripter, eliminating the need for a water bath, allowing for easier patient handling and greater patient comfort. Also in use is a state-of-the-art Shimadzu Hydrojust III cystoscopy table.

Experienced, professional staff—The staff of the New Jersey Kidney Stone Treatment Center is well-versed in lithotripsy treatment, and includes board-certified Anesthesiologists, critical-care trained nurses and skilled lithotripsy technicians.

Physician billing—Urologists treating patients at the Center have the advantage of billing their patients or third-party payers directly through their own offices.

Easy referral system—If desired, physicians can easily refer their patients to one of our staff Urologists for lithotripsy treatment.

HMO eligibility—The Center has established arrangements with most major area HMO's.

For more information regarding how the Center can help you and your kidney stone patients, call 1-800-542-8887 or (201) 937-8614.

New Jersey Kidney Stone Treatment Center

**Located at Robert Wood Johnson University Hospital
New Brunswick, New Jersey 1-800-542-8887**

The New Jersey Kidney Stone Treatment Center is operated by Health Horizons (ESWL), L.P., affiliated with the following hospitals: Community Memorial Hospital, Freehold Area Hospital, Helene Fuld Medical Center, Jersey Shore Medical Center, Raritan Bay Medical Center, Riverview Medical Center, Robert Wood Johnson University Hospital, St. Francis Medical Center, St. Peter's Medical Center, Somerset Medical Center.



PROFESSIONAL LIABILITY

EMPLOYEES' DISEASES

A company, company physicians, and others were liable for concealing employees' asbestos-related diseases, a New Jersey appellate court ruled. Several employees or their widows filed suit against the company where they worked and against its physicians for failure to warn them of the known risks of asbestos and their resulting asbestos-related medical conditions. The employees were all involved in working with pipes and tank insulation in the company's plants. They worked with and around asbestos-containing material on a frequent basis. Each employee received an annual physical examination and chest x-rays from company physicians. Employees claimed they were not told anything was wrong with them. On remand from an earlier decision, a trial court awarded them compensatory and punitive damages in the amount of \$1,382,500. Affirming the decision, the appellate court said there was sufficient evidence that the company and the company physicians engaged in a deliberate corporate strategy to conceal the employees' asbestos-related diseases that were discovered by company physicians. **(Reprinted with permission from *The Citation*, American Medical Association, Volume 58, December 15, 1988)**

SURGEONS AND THEIR TECHNIQUE

Today, particularly in surgical cases, plaintiffs increasingly add a count for failure to obtain informed consent to their more general claims of negligence. A recent opinion from the U.S. District Court of Maryland touching upon what a surgeon must say preoperatively to a patient is of interest (*Wachter versus United States* 689 F. Supp. 1420, 1988). Plaintiffs Jean Wachter and her husband sued Dr. Frank Billig, a naval surgeon, that had Dr. Billig made certain disclosures to Mrs. Wachter, she would not have permitted him to perform a coronary artery bypass graft. The case came before the court on a motion for summary judgment. The three negligence counts were dismissed with prejudice and the court focused on the consent issue, offering its analysis even though its determination of law made the discussion unnecessary.

The court said that the Federal Tort Claims Act does not permit a claim based on a surgeon's alleged failure to disclose his incompetence because that was a misrepresentation, excluded from the general waiver of sovereign immunity. Nevertheless, the court assumed that there was no exclusion and said the informed consent claim still failed on the merits. Addressing the plaintiffs' claim that had they known that Dr. Billig had some physical limitations and a comparatively poor surgical success rate, they would have chosen alternative therapy, the court pointed out that to prevail, they must show that the risk that would have altered her decision was not disclosed and that that risk materialized. As the only risk that materialized was that the bypass grafts were unsuccessful and, as the plaintiffs had not offered evidence that this was because of Dr. Billig's physical evidence, that argument was rejected.

The court then turned to plaintiffs' argument that the failure to inform the plaintiffs of the possibility of using the internal mammary artery

rather than the saphenous veins to supply the graft constituted a lack of informed consent. The court noted that Maryland law required physicians to disclose available therapeutic alternatives, but that there was a paucity of case law on what constitutes an alternative demanding disclosure. Turning to the patient's bill of rights, the court approved language saying that there must be "medically significant alternatives." It then asked whether a discussion of the use of an internal mammary artery (IMA) graft met that test in 1983. After a careful review of expert testimony, it concluded that the IMA graft was not in general use at that time and generally was not known to be superior.

The court's closing comment suggested it understood the need for limits on disclosure rules, saying: "It is inconceivable to this court that Maryland case law would require, for informed consent, that the surgeon discuss and obtain consent, and obtain consent beforehand as to the tactical details of the surgery, such as the location of the incision, the technique of the surgery, the type of sutures, the source of a graft, or other details of the operation. Such a requirement would be overly burdensome to the physician and would add nothing to the ability of a lay patient to give informed consent . . ." (*Medical Liability Monitor*, February 20, 1989)

ISOTRETINOIN GUIDELINES

The American Academy of Dermatology released detailed guidelines for prescription of the acne medication, isotretinoin, which is marketed under the trade name Accutane®. The drug, an effective treatment, has been associated with a number of possible side effects, the most significant of which is birth defects. The prescription of Accutane® is not peculiar to the specialty of dermatology; family and general practitioners, internal medicine specialists, and plastic surgeons utilize this drug.

Guidelines for prescribing isotretinoin (Accutane®) in the treatment of female acne patients of childbearing potential follow.

Patient Selection. In the treatment of females of childbearing potential, Accutane® should be used only for patients with severe, disfiguring, cystic acne. Accutane® must not be used by females who are pregnant or who may become pregnant while undergoing treatment. Accutane® should not be the therapy of first choice. It must be demonstrated that the patient is unresponsive to other standard therapies. The patient must be reliable and capable of understanding the physician's instructions on the use of Accutane®, the risks involved, and be willing to comply with these instructions. The patient must be able to comply with effective contraceptive measures (which may include abstinence) for at least one month prior to, throughout, and for at least one month after treatment. In the case of minors, the physical presence of the legal guardian is required when informed consent is obtained.

Physician Instructions. The physician has the responsibility of explaining fully to the patient the expected outcome of fetal exposure to Accutane®. This information must be understood by the patient and her legal guardian, if applicable. A written informed consent form must be signed by the patient and by the physician or third-party witness, and in the case of a minor patient, by the patient's legal guardian. A copy of the signed form will be given to the patient and in the case of a minor patient, to her legal guardian. The original consent form should be maintained in the patient's file. If the patient is sexually active, she must be using a highly effective form of contraception. She must be capable

of compliance. Gynecological consultation is suggested for patients who previously have become pregnant while using seemingly adequate contraception. Accutane® must not be prescribed unless it is documented in the patient's record that a highly effective form of contraception is used (which may include abstinence). A blood pregnancy test must be administered and shown to be negative within two weeks prior to beginning Accutane® therapy. Prescriptions for Accutane® must not be dispensed until the pregnancy test is reported as negative. Therapy should begin on day two or three of the next menstrual cycle. The physician should inform the patient that the Accutane® package includes an insert containing information which she should read before she begins using the medication. The physician should encourage the patient to ask questions concerning the risks associated with becoming pregnant while on the medication. Prescriptions should be written for no more than two weeks beyond a scheduled followup visit. Visits to the physician should be at least monthly and a repeat blood pregnancy test done monthly. Patients must be advised that the maximum duration of a single treatment course is 20 weeks. Contraceptive use must continue for at least one month after therapy completion. A blood pregnancy test should be done one month after completion of therapy.

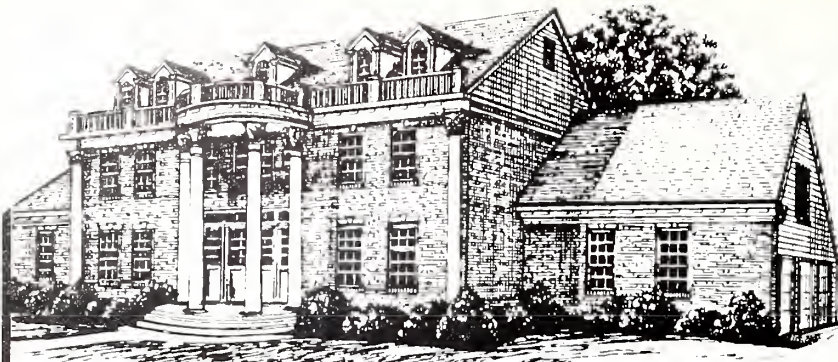
Many suits have been filed against Accutane's® manufacturer claiming birth defects, vision impairment, and gastrointestinal problems. Actions have been brought against prescribing physicians alleging "failure to provide sufficient guidance." (*Patient Rx Newsletter, Pennsylvania Medical Society, November 1988, Vol. 10, Nov. 6*)

FORCED CESAREAN SECTION

A \$3.5 million malpractice case filed in the Superior Court of the District of Columbia against George Washington University Medical Center and physicians, is bringing the issue of "forced cesareans" to the attention of the courts. The constitutionality of such "forced" procedures, which have been reported in at least 11 states, may soon be debated as a result. The mother and husband of a deceased young cancer patient, Angela Carder, have filed a lawsuit alleging wrongful death, medical malpractice, and deprivation of human rights. (*Stoner versus George Washington University Medical Center and Hospital, A-0330*). The mother, Nettie Stoner, alleges hospital personnel refused to carry out radiation or chemotherapy treatments recommended by Mrs. Carder's physician because she was carrying an unborn fetus.

The hospital went to court to obtain legal guidance on whether to place the right-to-life of the fetus before that of the mother. In June 1987, Judge Emmet G. Sullivan of the District of Columbia Superior Court ordered a cesarean section performed against the pregnant woman's wishes, even though he was aware that the surgery could hasten her death. The fetus was 26 weeks at delivery and died 2½ hours later. Mrs. Carder died two days later. A second suit brought on behalf of Mrs. Carder (*in the Matter of A.C., 87-609*) seeks to reverse the superior court's ruling on grounds it violated Mrs. Carder's right to privacy, liberty, and freedom from bodily invasion.

The malpractice suit was not anticipated by the hospital which said it sought the court's guidance. Yale University Professor Robert A. Burt told the *National Law Journal* that it is unlikely the hospital or its physicians will be found liable, even if the court's decision is reversed because the hospital and its personnel are given immunity when acting on a judge's order. (*Medical Liability Monitor, February 20, 1989*)



EXCLUSIVE 66 HOME COMMUNITY

Traditional and Contemporary styles in prestigious Montville. Homes start in the \$800,000 range and up to 6,000 Sq. Ft. — Call today to experience these breathtaking views.

Remax Realtors/Tim Crawford

Days: 808-0501 Eves: 628-9253

Standard Features:

- Central Air • Marble Foyers
- Central Vac • Intercoms
- Security Systems
- Tile Kitchens/Baths
- Hardwood Floors/All Living Areas
- State-of-the-Art Kitchens



DIRECTIONS: From Rt. 80 West take Pinebrook/Montville exit. Left onto Hook Mt. Rd. Right at first light, right at next light (Changebridge Rd.) Next right onto Woodmont, next right onto Rutledge, left on Windsor to Sales Office.

THE COMPLETE PRACTICE MANAGEMENT SYSTEM THAT TRULY REFLECTS THE NEEDS OF THE MODERN MEDICAL PRACTICE

**ELECTRONIC
CLAIMS**



Medicare, PA & NJ
Blue Shield, PA



Computerizing the Medical Profession since 1980

CHOSEN BY HUNDREDS OF DOCTORS
THE FUNCTIONALITY AND POWER OF OR-D SYSTEM IS
UNEQUALLED FOR THE PRICE.

Quality software solutions - A decade of experience
A wide range of hardware - Stability in the industry
Quality with commitment - Software that grows with you
Easy to use, GRADE 10. Dr. G.H. Brody, NY, NY.

Very EASY TO USE, very RELIABLE, PERFECT for my use
Dr. B. Goldstein, Philadelphia, PA.

User friendly, easy to backup, EFFICIENT information handling.
OR-D is VERY RESPONSIVE to problems & requests.
Dr. G.W. Miller, Mountainside Hospital, Verona, NJ.

Pop Windows, Paperless Claim, Insurance Billing, Practice Analysis, Appointment
Scheduling, Patient Profile Research, Integrated Letter Writing, Sent to Specialists &
Capitation Programs. Single or Multi-User, Customization, Ease of Use

**OR-D SOFTWARE COMES WITH A 90 DAYS
MONEY BACK GUARANTEE**

For information or demonstration, please call or write to:
OR-D SYSTEMS 1414 Brace Rd., Cherry Hill, 08034 609-795-8300
1-800-722-ORD1



Doctors Disposal Service, Inc.

2110 Maple Avenue
South Plainfield, NJ 07080

INC.

Licensed by:
STATE OF NEW JERSEY
Department of Environmental Protection

Professional removal of sharps and special
medical waste . . .

Disposal by incineration . . .

Reliable, worry free service . . .

Reasonable rates . . .

For information in New Jersey call toll free
1-800-447-0026



PRESIDENT'S PAGE

GRADUATION AT UMDNJ

Recently, I had the privilege, and the great pleasure, of attending the commencement exercises of the University of Medicine and Dentistry of New Jersey. It was a rainy day, but it was made bright by the joy and enthusiasm of the graduates. This was not a day for doctor-bashing, nor a time for complaining about the difficulties of being a physician, nor the occasion for discussing problems facing a doctor in today's society. It was a day of well-deserved celebration for the graduates and their families.

Governor Thomas Kean was the commencement speaker. To my great surprise and delight, he spoke of the need for physicians to become involved in the formulation of public policy. I was surprised, because he might well have been repeating our message, to our membership. He spoke of "linking" medicine with decisions made by government. He urged the graduates to "use your knowledge to speak out . . . share your knowledge with policymakers." He implored the graduates to "educate the public" and help the public to understand some of the choices and decisions. He discussed the need to "bridge the gap" between science and the public. Governor Kean acknowledged that government deals with problems that require the expertise and the knowledge of physicians.

We have long known this to be so. Public policy determines much that affects the health of our patients, the quality of care that they receive, and the way that we can deliver that care. Indeed, we are glad that Governor Kean agrees with us: physicians must be involved in the formation of health care policy, and indeed of public policy in general. This is part of our responsibility to ourselves, to our profession, and to our patients.

AMNJ AWARDS

Just a few hours after the commencement exercises, I attended the Annual Awards Dinner of the Academy of Medicine of New Jersey. I look forward to attending this event each year. Two physicians were honored for their outstanding achievements, as "Edward J. Ill Award" recipients. Dr. Ervin Moss was cited for his contributions to quality standards and safety in the practice of anesthesia, and Dr. James Oleske was honored for his pioneering efforts in the care of children with AIDS. (Dr. Oleske also had been honored earlier in the day, at the commencement exercises.) The Medical Society of New Jersey is proud of these two distinguished physicians. We know they both would agree there are many among our membership who serve their patients with distinction, dedication, and devotion, but without recognition. In a sense, the Edward J. Ill Award honors all of these physicians.

PRESIDENTS' CONFERENCE

On Wednesday, November 15, 1989, the Medical Society of New Jersey will hold a Presidents' Conference at our headquarters in Lawrenceville. This meeting was held regularly in the past, but has not been scheduled for several years. It now again is necessary, in order to keep pace with

rapidly changing events. The meeting will be open to presidents, presidents-elect, and executive directors of county societies, specialty societies, and similar groups. The agenda will include reports by the leadership of the Medical Society, and special consultants to the Medical Society. There will be ample time for full discussion, and to address the concerns and interests of the membership. Mark this date on your calendar, now.

CANDIDATES FOR OFFICE

For the past two years, the Nominating Committee has expanded its efforts to allow time to interview candidates for elective office in the Medical Society. This interviewing process has had many benefits. A negative aspect has been the division of the nominating process into two separate dates with interviews occurring in November, and the remaining interviews plus the nominating process itself occurring in January. Those candidates interviewed in November have appeared to be at a disadvantage. This year, all candidates will be interviewed on a single date, January 17, 1990. The Nominating Committee will perform all of its work on this day. Although this will require a longer meeting, we believe that it will be more advantageous to the candidates, as well as to the members of the Nominating Committee.

PRESIDENTIAL INVITATION

I am eager to attend your county medical society meetings, in order to hear what you have to say. Please invite me! Other members of the Board of Trustees also are available to attend your meetings, if I am unavailable for a specific date. ☐



EDITOR'S DESK

MSNJ ANNUAL MEETING

This issue of *NEW JERSEY MEDICINE* contains the transactions of the 223rd Annual Meeting of the House of Delegates of the Medical Society of New Jersey. The accommodations at the Sheraton Meadowlands Hotel were excellent, the meeting space was more than adequate, and the dinner and banquet food was a cut above usual hotel fare. It also was rewarding to have Dr. Paul Hirsch installed as the latest in the line of outstanding presidents of the Society. We anticipate a year of accomplishment and innovation.

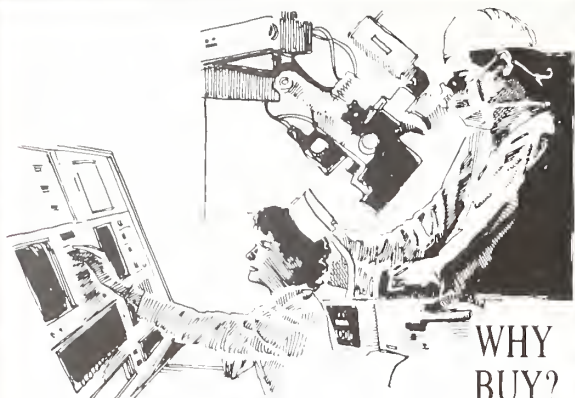
But many felt an underlying uneasiness about our problems—a feeling of frustration mixed with pessimism in trying to deal with the oppressive forces regulating us. The reports of the presidents of the medical societies of our neighboring states, especially Massachusetts, only deepened the mood. Perhaps as a result, some of the agenda items that would have generated hours of debate in the past, passed with a minimum of acrimony and without apparent polarization of the House of Delegates. These included:

- Agreement that sexual exploitation in professional relationships is unethical and unprofessional, and for the AMA to endorse the policy.
- Restatement, basically a reaffirmation, of the Society's position on abortion.
- Reconsideration by this Society and by the AMA of collective bargaining.
- Agreement to publish the names of delinquent physicians in *NEW JERSEY MEDICINE*.
- Requirement that third-party payors, not physicians, be obliged to explain benefits to their subscribers.

Somewhat more debate centered around the surcharge on malpractice premiums, as proposed by the commissioner of insurance. We were treated to a most erudite discussion of the legal ramifications by our special counsel, Judge Herbert Stern; it clarified the situation and will enable us to do the most good for the greatest number of New Jersey physicians.

Most debate centered on Medicare and its various problems, including: the inadvisability of participation by physicians in the program; placing the onus of coding and attestation on the hospitals, not on the physicians; removal of discrimination against nonparticipating physicians; establishment of an arbitration mechanism between HCFA and the AMA; rescission of the ICD-9-CM coding requirements; and correction of arbitrary denials.

Many items, referred to the American Medical Association, will have seen some action by the time this appears in print. Nevertheless, they, and the many other topics discussed at the House of Delegates, deserve your careful digestion. Bon Appetit. □



WE PROVE IT COSTS LESS TO LEASE!

Medical & Office Equipment Leasing
We Are The Experts!
Call For Information

HTFS

Contractors for
 Metro West and
 Metro Essex Home Care

HI-TEC FINANCIAL SERVICES

2191 MILLBURN AVE. • MAPLEWOOD, NJ
 (201) 763-3256

DEBTS COLLECTED

*by PROFESSIONALS
 for PROFESSIONALS*

Deal directly with the Law offices of

SOL ROSENBERG P.A.

366 Clifton Ave.

P.O. Box 1325

Clifton, N.J. 07105

INQUIRIES INVITED

Phone (201) 340-2800

Fax (201) 340-2807

*35 Years experience
 in medical collections*

References upon request.

YOCON[®]

YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

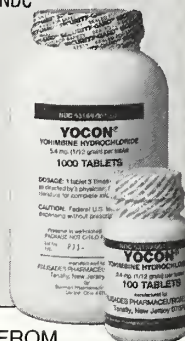
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE EXCLUSIVELY FROM
**PALISADES
 PHARMACEUTICALS, INC.**
 219 County Road
 Tenafly, New Jersey 07670
 (201) 569-8502
 1-800-237-9083



BOOK REVIEWS

COMPUTED TOMOGRAPHY WITH MRI CORRELATION

Joseph K.T. Lee, Stuart S. Sagel, Robert T. Stanley. New York, NY, Raven Press, 1988. This is the second edition of a text that has become a standard reference in body computed tomography (CT). The editors should be commended for including the role of magnetic resonance imaging (MRI) in their discussion of the advances of CT. The format of the book is similar to its predecessor. The physics of CT and MR are reviewed briefly. The first edition contained a list of CT scanning protocols used by the editors; this work adds a synopsis of MR protocols for extracranial examination. The main chapters review the body from the neck down. Although the emphasis on this clearly written text is on CT, extensive MR correlation is included. As in the previous edition, the scans and accompanying radiographs are of high quality. Especially valuable are the sections where the indications of MR are presented. The union of extensive descriptions of the CT findings of various diseases and the MR appearances gives the reader an excellent overview of the field. The book's final chapter on pediatric applications examines the subject of pediatric body CT systematically. The book is an excellent review of body CT and is highly recommended. The MR correlation helps in highlighting how the two modalities interact in the diagnostic evaluation of the patient. □ Neil B. Horner, MD

CURRENT PROTOCOLS IN MOLECULAR BIOLOGY

Green Publishing Associates and Wiley-Interscience, 1988. This two-volume set is edited by a group of scientists at Harvard Medical School: Frederick M. Ausubel, Roger Brent, Robert E. Kingston, David D. Moore, J.G. Siedman, John A. Smith, and Kevin Struhl. A subscription for supplements in the quarterly update service also is available. This format enables researchers to stay up to date in the constantly developing molecular biology methodology.

Current Protocols in Molecular Biology includes the following topics: 1) *E. coli*, plasmids, and bacteriophages; 2) preparation and analysis of DNA; 3) enzymatic manipulation of DNA and RNA; 4) preparation and analysis of RNA; 5) construction of recombinant DNA libraries; 6) screening recombinant DNA libraries; 7) DNA sequencing; 8) mutagenesis of cloned DNA; 9) introduction of cloned DNA into mammalian cells; 10) analysis of proteins; 11) immunology; 12) DNA-protein interactions; and 13) *Saccharomyces cerevisiae*. This set is large and useful as a laboratory manual. Each section begins with a brief, readable general introduction followed by a more detailed overview of the particular topic. For individuals not familiar with specific methods, these sections are particularly useful. For example, the overview of DNA libraries discusses the need to anticipate how you will screen the libraries for your particular DNA and how that will determine construction of the library. Cross referencing within the text enables the reader to further pursue either more background or other techniques. As one proceeds into the protocol portion of each section, there are italicized notes which state the most important aspects of particular techniques. Commentary after

the detailed protocols then are provided for each section, including more background information, critical parameters, anticipated results, and time considerations.

The organization and content of *Current Protocols in Molecular Biology* will benefit both experts and novices. I highly recommend these volumes for individuals interested in staying current with developments in molecular biology. The two-volume core book costs \$165 and the subscription update service is \$95. □ Jonathan Yavelow, PhD, Chairman, Department of Biology, Rider College

INTERVENTIONAL RADIOLOGY

Christos Anthanoulis, Reginald Greene, Richard Pfister, Glenn Roberson (eds). Philadelphia, PA, W.B. Saunders, 1988. This well-written, comprehensive text from the Massachusetts General Hospital applies a practical approach to a broad range of interventional procedures. The book divides the body into five areas—cardiovascular system, genitourinary system, abdomen, chest, and the central nervous system—along with a combined section that includes breast, musculoskeletal system, and pediatric population. High-quality angiograms complement the hands-on approach of the text. Especially informative reading is found in the sections that discuss gastrointestinal bleeding and interventional urological procedures. Besides the discussion on the technical factors involved in each procedure, the editors have added ample amounts of data concerning the clinical aspects of each disease entity. These details provide the reader with both a broad understanding of the techniques as well as with clinical indications and possible complications. Overall, this is an excellent text and is highly recommended. □ Neil B. Horner, MD

DISORDERS OF THE SPLEEN

Barbara S. Wolf, MD, Richard S. Neiman, MD. Philadelphia, PA, W.B. Saunders Company, 1989. This is the 20th text in the series of major problems in pathology and is devoted to diseases of the spleen. This virtually complete reference text will be useful to pathologists and clinicians, especially hematologists and oncologists.

It is unlikely that any pathologist will encounter even a fraction of the diseases discussed, even in a busy practice, but the quest for the unusual is justification enough for most pathologists. The authors organize the book in a logical, if unusual, fashion according to the various histological divisions of splenic architecture. There are three major divisions of the text. The first details anatomy and physiology. The second section covers disorders of the white pulp and includes Hodgkin's disease, malignant lymphomas, and granulomatous diseases. The last part encompasses the red pulp and describes leukemias and myeloproliferative disorders. The photographs and photomicrographs generally are of good quality. Some of the low-power magnifications do not reproduce well, however. It is surprising that details of splenic function and morphology remain unknown or controversial. The references cited after each chapter will serve the reader in gaining ready access to the medical literature concerning this very 'neglected' organ. The usual delay between manuscript submission and publication results in few references after 1986. Interestingly, the most frequent derangement of the spleen that brings it to pathologists' attention, namely trauma, is given scant attention. Another small quibble is the inconsistent use of the apostrophe in eponymic disorders. In short, this is an interesting textbook which should be a part of any pathologist's library or any hospital medical library. □ Marvin Shuster, MD

Polyendocrine Failure with Hypogonadism

JESUS R. ALFONSO, MD
MICHAEL H. GOLDMAN, MD
JEFFREY KOCHER, MD

Primary gonadal failure, in males with autoimmune endocrinopathies, rarely has been described. We present a unique case of transient hypergonadotropic hypogonadism in a male with type 2 polyglandular failure (Addison's disease and autoimmune hypothyroidism).

In 1926, E.B. Schmidt reported the first case of combined endocrine failure. He described Addison's disease in association with primary thyroid failure.¹ In 1963, Carpenter expanded this syndrome to include diabetes mellitus.² In 1967, Turkington found hypogonadism to occur in nearly one-fourth of the patients (primarily females) with combined endocrine failure.³ In 1981, Neufeld classified two types of polyglandular syndromes: Type 1 polyglandular failure (PGF) characterized by Addison's disease in association with hypoparathyroidism and/or chronic mucocutaneous candidiasis associated with other nonendocrine disorders, and Type 2 PGF syndrome referring to the constellation of Addison's disease, autoimmune hypothyroidism, and/or insulin-dependent diabetes mellitus (Schmidt's syndrome), as well as other associated nonendocrine disorders.⁴

Gonadal failure, although previously well documented in the PGF syndrome, has been found mainly in females. Male hypogonadism rarely has been confirmed, and only one case of documented permanent hypotestosteronemia with elevated gonadotropins has been reported.⁵

CASE REPORT

A 34-year-old white male was admitted to Englewood Hospital with the complaints of weakness, easy

fatiguability, 20-pound weight loss, and anorexia over a two-month period. The patient's prior medical history was noncontributory and his sexual development and fertility were normal. He denied any loss of libido or sexual dysfunction. He had two children ages three and two. Physical examination showed a thin male with a diffuse ashen appearance. No orthostatic blood pressure changes were noted. The thyroid gland was enlarged and firm, but without nodularity. The remainder of the physical examination demonstrated normal adult axillary and pubic hair and normal testicular size (3.5 x 2.5 cm bilaterally). His phallus was adult size. Laboratory examination was significant for eosinophilia (total WBC 8,700 with 800 eosinophils per mm³), an elevated serum potassium of 7.0 mEq/L (normal 3.5 to 5.2), and a low serum sodium of 122 mEq/L (normal 132 to 142). The total thyroxine was 2.8 mcg/dl (normal 4.5 to 11.5), T3 resin uptake was 29 percent (normal 30 to 40 percent), and TSH was elevated at 45 microIU/ml (normal less than 3 microIU/ml).*

Basal cortisol was 9 mcg/dl (normal 7 to 25 mcg/dl), and cortisol level post-ACTH stimulation with 250 mcg of Cortrosyn intravenous bolus was 10 mcg/dl. Basal ACTH level, unfortunately, was not obtained. The luteinizing hormone (LH) was elevated at 28 microIU/ml (normal 2 to 20 microIU/ml), and the testosterone was low at 221 ng/dl (normal > 300 ng/dl). The follicular stimulating hormone (FSH) was 12 microIU/ml (normal 2 to 20 microIU/ml), and the prolactin was 8 ng/dl (normal

*Endocrine data from Nichol's and Roche laboratories; T3 resin and T4 from Englewood Hospital laboratory.

Dr. Alfonso is a resident, Department of Medicine, and Drs. Goldman and Kocher are affiliated with Englewood Hospital. Requests for reprints may be addressed to Dr. Goldman, 600 Palisades Avenue, Englewood Cliffs, NJ 07632.

5 to 22 ng/dl). Antiadrenal antibodies were negative.

Antithyroglobulin antibodies and thyroid microsomal antibodies were positive with titers of 47 U/ml (normal < 10U/ml) and 700 U/ml (normal < 25 U/ml), respectively. A tuberculosis skin test was negative. Testicular biopsy and sperm counts were not performed at this time.

Replacement therapy with 1.0 mg of dexamethasone and 0.1 mg of fludrocortisone daily improved many of the patient's symptoms and corrected the hyponatremia and hyperkalemia. One month later, repeat testosterone (501 ng/dl) and LH (4.5 MIU/ml) levels also returned to normal; however, TSH remained elevated at 44 MIU/ml. Subsequently, levothyroxine 0.1 mg daily was started. This was followed by normalization approximately three months later, of the total thyroxine and TSH level (9 mcg/dl and 0.8 microIU/ml, respectively), with the patient noting progressive improvement in physical activity and return of appetite.

DISCUSSION

Primary adrenal insufficiency is a rare disorder caused by autoimmune destruction of the adrenal gland in about 80 percent of cases. Other causes are numerous, including tuberculosis, fungal infections, amyloidosis, sarcoidosis, hemochromatosis, certain drugs (e.g. metyrapone), adrenal infarction due to emboli, anticoagulation, disseminated intravascular coagulation (DIC), trauma, and toxemia of pregnancy.⁶

In autoimmune adrenal disease, antiadrenal antibodies are found in about 65 percent of patients. Both specific and nonspecific (steroid cell) antibodies have been demonstrated. The specific antibodies react only with adrenal cells, whereas the steroid cell antibodies are capable of reacting with several steroid-producing tissues, including the theca interna and corpus luteum of the ovary, the placental trophoblast, and interstitial cells of the testis. Although no adrenal antibodies were found in this patient, the presence of thyroglobulin and

thyroid microsomal antibodies suggest an autoimmune pathogenesis. A lower incidence of antiadrenal antibodies has been noted in males (50 percent) as compared to females (70 percent) with PGF.⁷

Of special interest in this case is the return to normal of the initially low testosterone and high LH levels, following institution of physiologic steroid replacement. The reversal of thyrotropin excess with autoimmune hypothyroidism, and normalization of hyperprolactinemia after glucocorticoid treatment of primary adrenal insufficiency have been documented previously. However, transient reversible hypergonadotropic hypogonadism has not been described.^{8,9}

The mechanism(s) through which adrenal hormone replacement improves the function of other endocrine glands remains speculative. The anti-inflammatory and lympholytic properties of glucocorticoids may directly diminish the immune-mediated glandular damage. Alternatively, glucocorticoids may have a direct influence on pituitary secretion. Both prolactin and TRH may be lowered by steroid administration, however, only at pharmacologic doses.¹⁰

In contrast to the few previously reported cases of male hypogonadism, this patient illustrates a reversible course of primary hypogonadism. Weinberg's patient clearly showed progressive and permanent primary hypogonadism over a six-year period, as documented by borderline low testosterone and elevated FSH and LH levels.⁵ Turkington's patients have poorly documented endocrinopathies with no testosterone deficiency reported, and only 1 of 3 of his reported cases with "atrophic testis" had elevated urinary gonadotropins.³ Irvine additionally reported on only 1 of 79 male patients who had testicular failure associated with Addison's disease. However, only abnormalities in spermatogenesis are mentioned, and no laboratory data are given to confirm his findings.⁷ ■

REFERENCES

1. Schmidt MB: Eine biglandulare ErKrankung (Nebennieren und Schilddrüse) bei morbus Addisonii. *Dtsch Path Ges* 21:212-215, 1926.
2. Carpenter CCJ, Solomon N, Silverberg SG, et al.: Schmidt's syndrome (thyroid and adrenal insufficiency). *Medicine* 43:153-180, 1964.
3. Turkington RW, Lebovitz HE: Extra-adrenal endocrine deficiencies in Addison's disease. *Am J Med* 43:499-507, 1967.
4. Neufeld M, Maclaren NK, Blizzard RM: Two types of autoimmune Addison's disease associated with different polyglandular autoimmune (PGA) syndromes. *Medicine* 60:355-362, 1981.
5. Weinberg V, Kraemer FB, Kammerman S: Coexistence of primary endocrine deficiency. *Am J Med Sci* 272:215-220, 1976.
6. Greenspan FS, Forsham HP: *Basic and Clinical Endocrinology*. Los Altos, CA, 1986, pp. 288-307.
7. Irvine WJ, Barnes, EW: Addison's disease, ovarian failure, and hypoparathyroidism. *Clin Endocrinol Metab* 4:379-433, 1975.
8. Topliss DJ, White EL, Stockigt JR: Significance of thyrotropin excess in untreated primary adrenal insufficiency. *J Clin Endocrinol Metab* 50:52-56, 1980.
9. Kelder ME, Nagamani M: Hyperprolactinemia in primary adrenocortical insufficiency. *Fertility Sterility* 44:423-425, 1985.
10. Sowers JR, Carlson HE, Brautbar N, Hershman JM: Effect of dexamethasone on prolactin and TSH response to TRH and metoclopramide in man. *J Clin Endocrinol Metab* 44:237-241, 1977.

Microbiological Contamination of the Ocean, and Human Health

MOLLY JOEL COYE, MD, MPH
MARCIA GOLDOFT, MD, MPH

Perhaps no other environmental issue has received more attention in recent years than the pollution of swimming beaches at the New Jersey shore. Recreational beach activities are enjoyed in New Jersey by residents and visitors alike. The New Jersey shoreline has 120 miles of coastal beaches, including numerous recreational sites. Spurred by beach closings, there has been increasing concern expressed about illnesses which may be related to sewage effluent released from treatment plant ocean outfall pipes.

MSNJ played a pivotal role in convening an advisory group that met with the Department of Health to discuss ocean water quality. As a result, in spring 1987, the governor and the Legislature directed the Department of Health to determine if microbiological contamination of the ocean resulting from human activities was leading to increased risk of infectious diseases among swimmers.

The link between water contamination and illnesses among swimmers can be established epidemiologically by determining the swimming-associated illness rates, which are the differences in rates between swimmers and nonswimmers. To identify these rates, it is necessary to identify those

at risk, the level of exposure to pathogens, and the expected health outcome resulting from exposure.

Not all illnesses experienced by beach visitors or by swimmers are related to the ocean. Travelers are likely to have higher rates of illnesses from increased exposures to contaminated food and to ill individuals. Increased rates of a variety of mild infectious illnesses also are expected for swimmers due to reduction of normal skin and mucous membrane barriers and due to transmission of illnesses between swimmers. Swimmer-to-swimmer transmission has been demonstrated epidemiologically for respiratory and gastrointestinal infections. Additional illnesses may occur if the swimming water contains human pathogens.

The high number of necessary tests to cover possible pathogens and the lack of tests for certain pathogens, such as Norwalk-type agents, make environmental sampling for pathogens a formidable task. Assessing water quality, therefore, depends on measuring indicator organisms rather than actual pathogens. The most commonly used indicator organisms are coliform bacteria, present in the intestines of warm-blooded animals. Fecal streptococci, specifically enterococci, have been suggested as an alternate indicator organism.

The Department of Health study used four indicator organisms. In addition to coliform and enterococci levels, samples were tested for the spores of *Clostridium perfringens* and for a bacteriophage, a bacteria-infecting virus. To consider the possibility that even the four tests did not detect the presence

Dr. Coye is New Jersey State Commissioner of Health. Dr. Goldoft is a research scientist for the New Jersey State Department of Health. Requests for reprints may be addressed to Dr. Goldoft, New Jersey State Department of Health, Division of Occupational and Environmental Health, CN 360, Trenton, NJ 08625-0360.

NEW JERSEY COASTLINE

Study Beaches

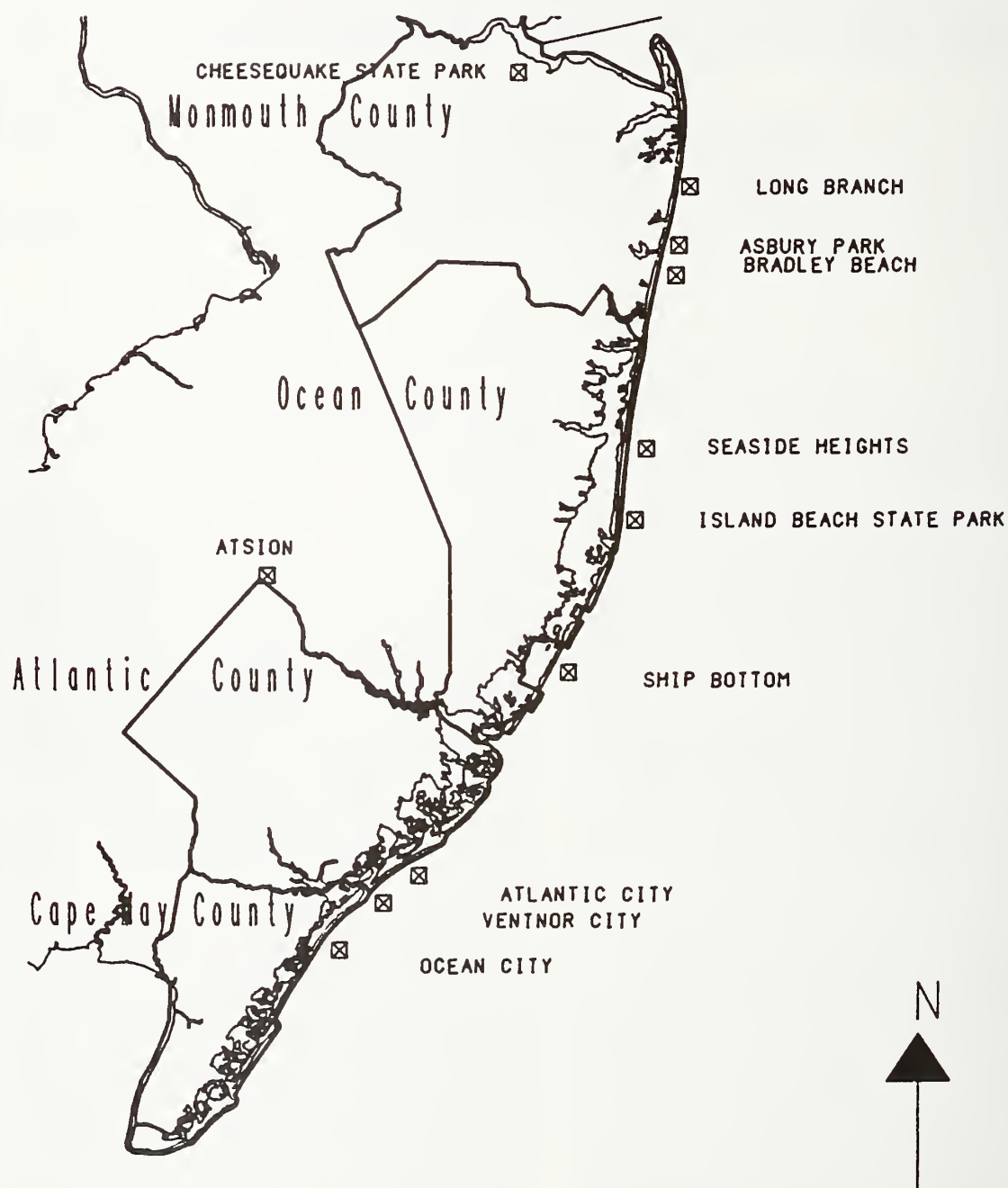


Figure 1. The nine ocean beaches and two lake beaches selected for the 1988 Department of Health study.

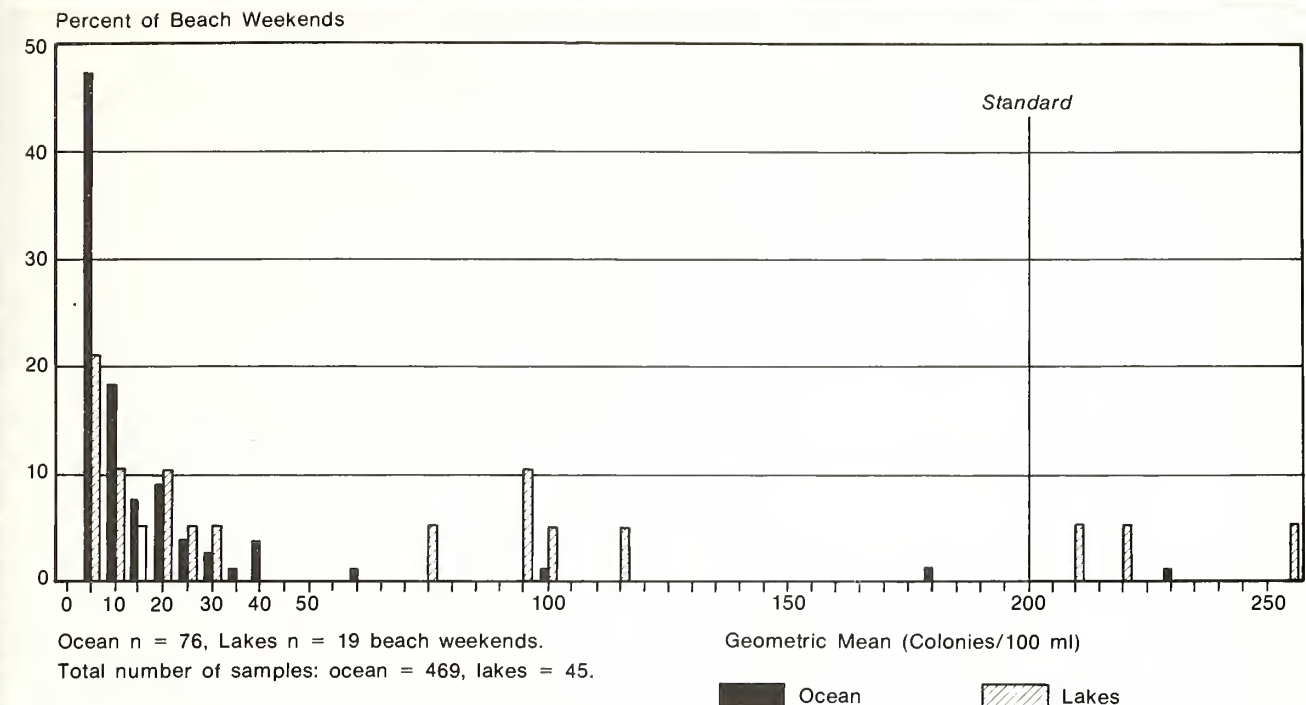


Figure 2. Fecal coliform. Geometric means from the NJDOH 1988 sampling.

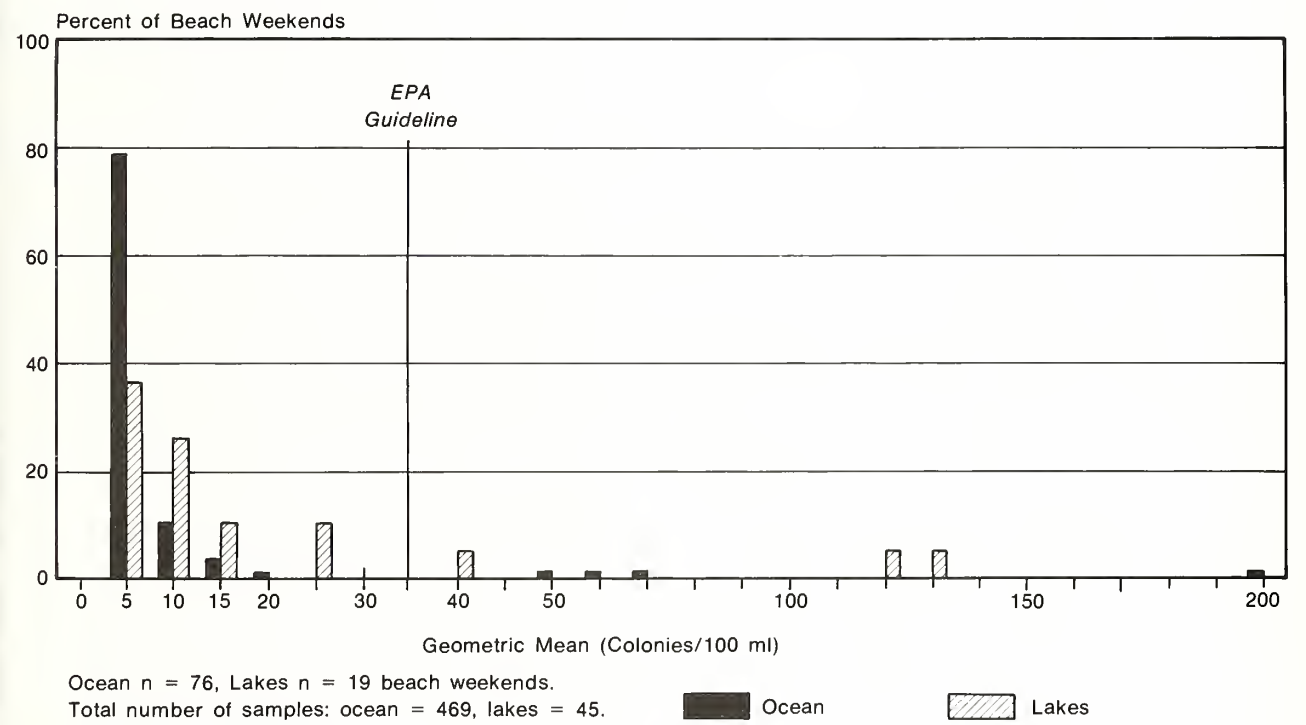


Figure 3. Enterococci. Geometric means from the NJDOH 1988 sampling.

of pathogens, two comparison beaches were included in the study that, by inspection and by previous water quality testing, did not have evidence of microbiological contamination.

The level of exposure for a swimmer depends on the microbiological contamination of the swimming water. At present, all New Jersey sewage treatment

plants with ocean outfall pipes discharge chlorinated effluents. These effluents contain intestinal microorganisms resistant to chlorine, primarily viruses. If ingestion of sewage-contaminated water occurs, the most typical health outcome would be acute gastroenteritis characterized by nausea, vomiting, diarrhea, and fever occurring within several days of

exposure. The same syndrome results if the causative organisms are transmitted due to contaminated food or from one person to another and may be indistinguishable from other conditions such as travel sickness.

Demonstrating an association between swimming and illness, therefore, is complex. The Department of Health presented the question to consultants and a science advisory group including members from government, medicine, academia, and environmental organizations. Anecdotal reports or physician-based surveillances were considered unlikely to provide comprehensive health information. These groups recommended a large-scale epidemiological study of beach visitors.

METHODS

Sites for the study included beaches chosen for variability in geographic location along the coast and in water quality. State and local monitoring results did not identify any beaches with consistent or heavy water contamination, so the actual selection of beaches for the 1988 study was based on a number of criteria: the high density of population using the site, potential for occasional contamination, geographic distribution along the coast, and the sites' distances from the Department of Health laboratory in Trenton. A total of nine ocean beaches and two lake beaches were selected for the study (Figure 1).

Swimming activity, health outcome, and water quality monitoring were the necessary study components. Swimming activity was determined by interviews of households at beaches. Health outcome was determined by followup telephone interviews three to four days after the beach visit. The four selected microbiological assays were done on water samples collected at the interview beaches during the same time periods.

The Department of Health conducted the epidemiological interview study in 1988 with the assistance of independent consultants. Results of the health study are based on data reported by 5,378 households with 16,089 individuals. Illness rates were developed by age group and swimming status.

WATER QUALITY MONITORING

Data from two years of microbiological monitoring along the coast found water quality was very good except for a few isolated episodes with known contamination sources. Samples collected offshore by helicopter between the outfall pipes and the beaches did not find significant levels of the indicator organisms. In 1988, microbiological contamination was not identified at the swimming beaches except for a single episode (Figures 2 to 5). Overall, water quality was excellent as measured by the four indicator organisms.

In addition, there was evidence that offshore water quality has been improving. *C. perfringens* levels

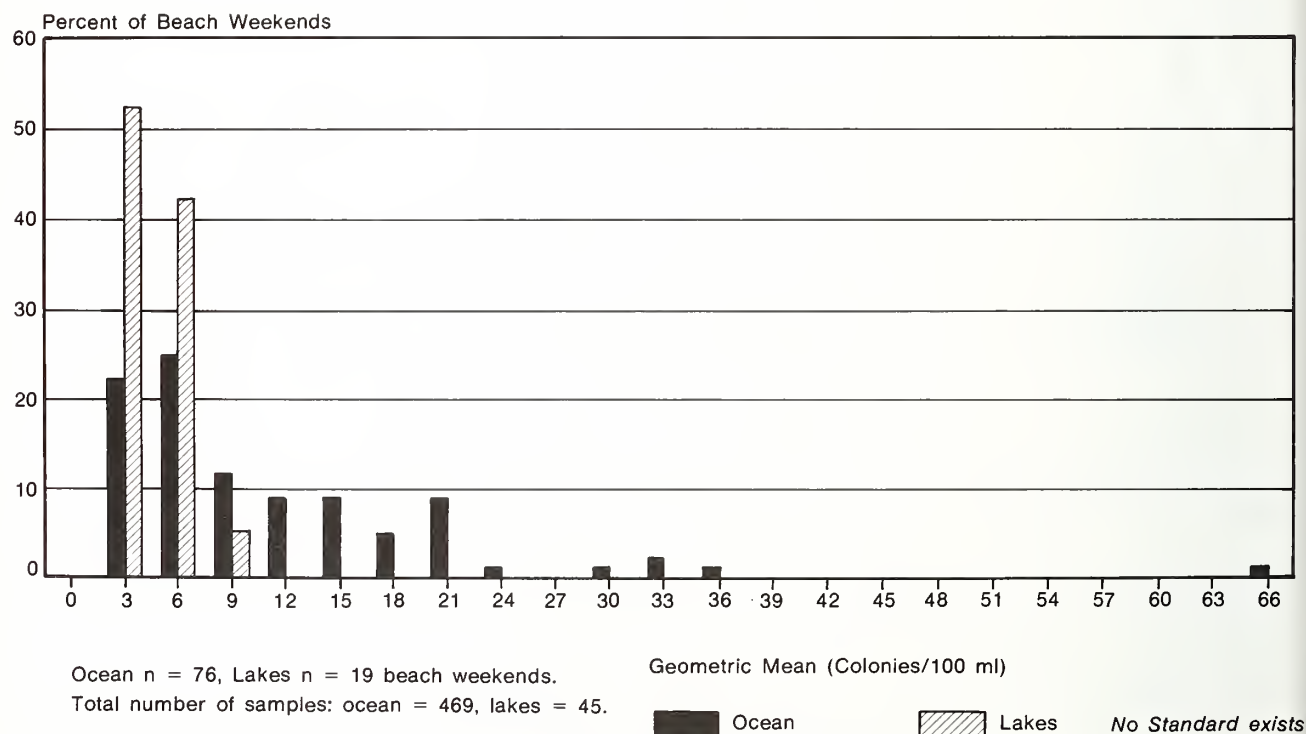
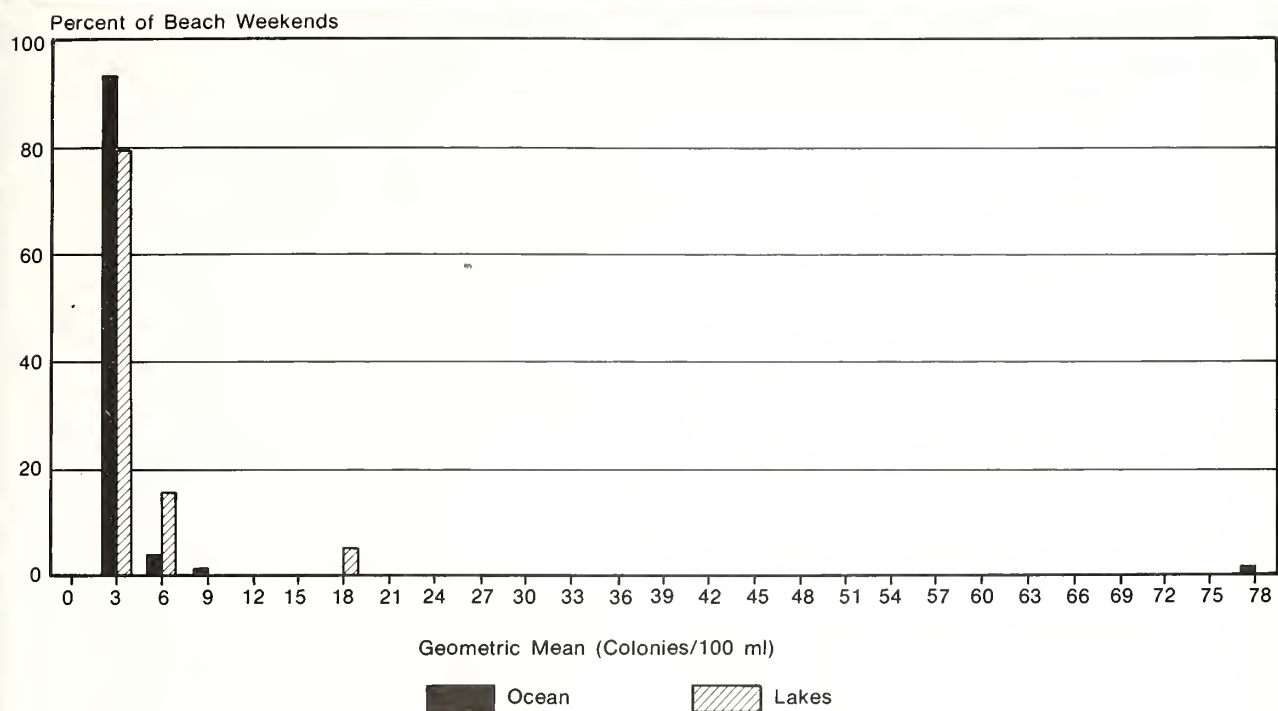
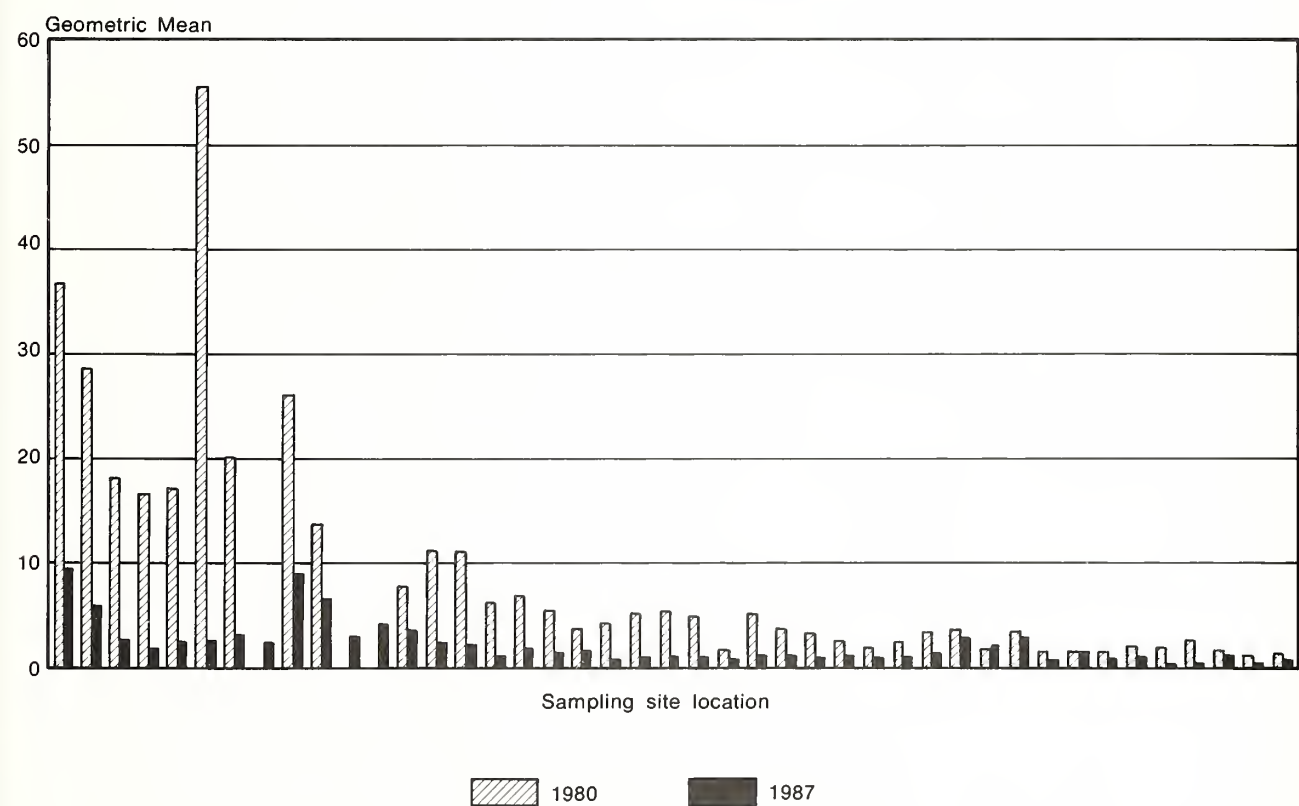


Figure 4. *Clostridium perfringens*. Geometric means from the NJDOH 1988 sampling.



Ocean n = 76, Lakes n = 19 beach weekends.
 Total number of samples: ocean = 469, lakes = 45.
 No Standard exists

Figure 5. Bacteriophage. Geometric means from the NJDOH 1988 sampling.



n = 40 sites
Figure 6. *Clostridium perfringens*. Geometric means from an EPA sampling network, 1980 and 1987.

Table. Symptom rates per 1,000 study participants by swimming status.

Group	Symptom					
	HCGI	Sore Throat	Ear Infection	Red Eyes	Skin Rash	One or More
Ocean						
Got head wet	20.8	44.5	19.7	41.0	24.3	119.9
Not in water	8.6	21.9	9.8	14.4	13.7	56.2
Lake						
Got head wet	30.9	45.6	21.9	69.0	35.2	162.1
Not in water	13.6	29.2	3.9	11.7	19.5	62.3

HCGI = Highly credible gastrointestinal illness.

were tested at 40 offshore stations along the coast in 1980 to 1981 and in 1987. There were reductions at 38 sites and stable or slightly increased counts at only two sites (Figure 6).

EPIDEMIOLOGICAL RESULTS

As expected, children had higher illness rates than adults, and swimmers had higher rates than non-swimmers. Of the five symptoms reported, red, itchy eyes and sore throats, most commonly were reported for swimmers and nonswimmers, followed by skin rash, gastroenteritis, and ear infections (Table). At lakes, the most common symptom was red eyes, reported at rates of 69.0/1,000 for swimmers and 11.7/1,000 for nonswimmers. At ocean beaches, the most common symptom was sore throats, reported at rates of 44.5/1,000 for swimmers and 21.9/1,000 for nonswimmers. Gastroenteritis among swimmers occurred at rates of 30.9/1,000 for lakes and 20.8/1,000 for ocean beaches, compared to rates among nonswimmers of 13.6/1,000 at lakes and 8.6/1,000 at ocean beaches.

Eye, throat, and skin infections generally do not result from intestinal organisms, while ingestion of sewage-contaminated water during swimming would be predicted to result in diarrheal illnesses. The predominance of nonintestinal infections suggests that the major sources of infection transmission were not related to contaminated swimming water.

In addition, illness rates did not differ for swimmers at the two comparison beaches as opposed to the remainder of the ocean beaches and were similar or lower at the ocean beaches as compared to the lakes. Combined with the good microbiological water quality occurring during the study, these results are indicative of safe conditions for swimmers at coastal beaches. Some infections will occur as the natural consequence of swimming, but are not the result of contaminated water.

The low health risk for ocean swimming is supported by anecdotal reports. To promote case report-

ing by health care providers, pamphlets from the Department of Health were distributed in 1988 during the interviewing process and through local health departments and county medical societies. These pamphlets with a contact telephone number were given to over 7,000 households at beaches. In the course of the summer, there were 18 telephone calls to the Department of Health relating illness to swimming. Of these calls, 10 concerns referred to ocean swimming and covered a range of illnesses not necessarily related to swimming.

RECOMMENDATIONS

Based on the study results and the events of 1988, the New Jersey Department of Health developed four public health recommendations.

1. The Department of Health will be continuing surveillance with the assistance of local health professionals. Telephone consultation is available for physicians, and illness outbreaks will be investigated as needed.

2. The Department of Health endorses continuation of the weekly ocean water quality monitoring programs conducted by local and state agencies to ensure that sewage treatment plants meet state and federal standards and to provide the public with information about the beach water contamination levels.

3. The Department of Health recommends that beachgoers heed any official announcement or posting indicating that swimming is restricted based on monitoring results.

4. The Department of Health will continue to work with the Department of Environmental Protection to protect water quality at all New Jersey beaches.

Continued improvement in beach water quality can be accomplished through efforts to identify and eliminate sources of contamination. Such efforts are vital to ensure the protection of the New Jersey shore and the health of New Jersey's beachgoers. ■

Chronic Confusional State

WILLIAM J. MULLALLY, MD
MICHAEL RONTAL, MbBCh
KENNETH HUFF, MD
NORMAN GESCHWIND, MD

An acute confusional state after infarction in the distribution of the right middle cerebral artery has been described. Patient recovery usually is excellent. Some patients, however, do not improve, resulting in a chronic confusional state.

An acute confusional state (ACS) has been described in patients with infarction in the distribution of the right middle cerebral artery by Geschwind and Mesulam,^{1,2} as having the following characteristics: inattention, easy distractibility, disorientation with paramnesia, and inability to maintain a logical train of thought. There had been other reports of confusion after infarcts in areas supplied by the right posterior or anterior cerebral arteries^{3,6} but not the right middle cerebral artery. This state usually improves within weeks.² We now describe three patients who did not improve; with a "chronic confusional state" (CCS).

Dr. Mullally is affiliated with the Department of Medicine, The Medical Center at Princeton. Drs. Rontal and Huff are affiliated with Beth Israel Hospital, Harvard Medical School, Boston. Dr. Geschwind is deceased. Requests for reprints may be addressed to Dr. Mullally, 11 State Road, Suite 200, Princeton, NJ 08540.

CASE REPORT 1

A 66-year-old, right-handed hypertensive man was well until he suffered the sudden onset of a left hemiplegia, hemihypesthesia, and homonymous hemianopsia. He was alert and oriented to person, but not to place and time. He thought he was in a branch of the hospital in another city, although he knew the correct name and address of the institution (paramnesia). Speech was fluent with normal comprehension and repetition. He could read but not write. "Military" or "legalistic" type speech was evident. He was markedly inattentive and easily distracted. Computed tomography (CT) revealed a large lucent area in the territory of the right middle cerebral artery (Figure 1). One year later, there was no change on examination.

CASE REPORT 2

A 70-year-old, right-handed man with a history of

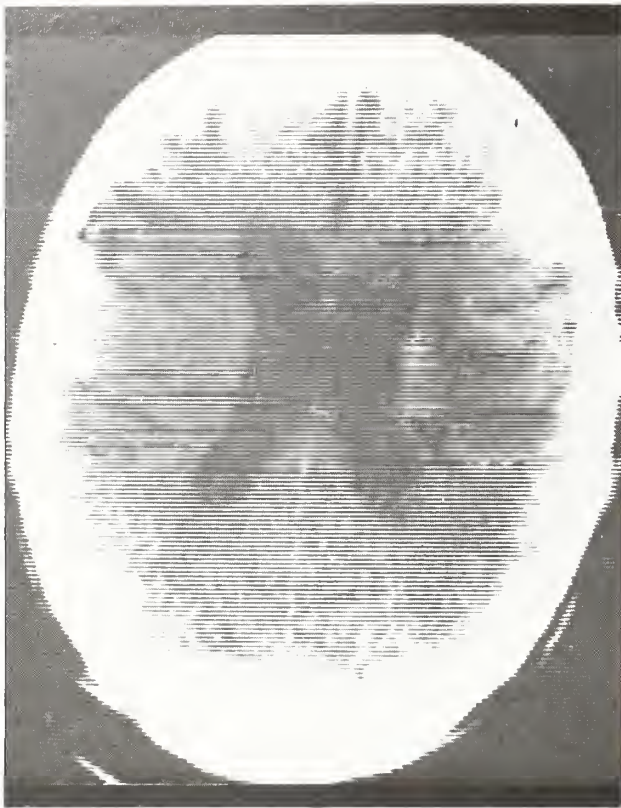


Figure 1.



Figure 2.

Figure 1. Large lucent area in the right middle cerebral artery. **Figure 2.** Large, right frontotemporoparietal lucency. **Figure 3.** Infarction in the right middle cerebral artery.

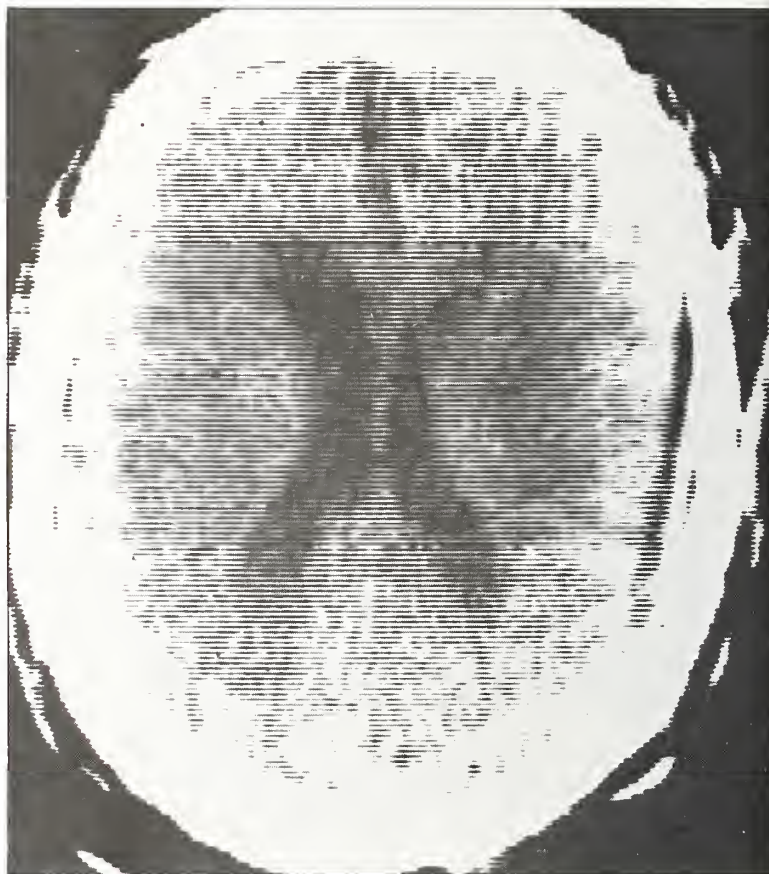


Figure 3.

manic-depressive illness and adult-onset diabetes mellitus was mentally alert, with normal intellectual functioning, until he had a stroke. Examination revealed a left hemiparesis and marked confusion. More than one year later, he was alert and oriented to his name only. He did not know the date and thought he was in a branch of the hospital in another state. There was no aphasia but writing was poor. He was inattentive and tended to ignore the left side of space and his body. Elementary signs included left hemiparesis, hemihypesthesia, hyperreflexia, homonymous hemianopsia, and a Babinski's sign. CT showed a large, right frontotemporoparietal lucency (Figure 2).

CASE REPORT 3

This 72-year-old, right-handed man had a history of blindness due to retinitis pigmentosa, compensated congestive heart failure, and coronary artery disease. He suddenly became confused. On examination, he was alert and oriented to person only. He exhibited paramnesia. Speech was normal and comprehension was intact. He could read but was agraphic. He was inattentive. Signs included mild hemiparesis, hemihypesthesia, hyperreflexia, and Babinski's sign, all on the left. CT revealed infarction in the distribution of the right middle cerebral artery (Figure 3). The hemiparesis improved, but the confusional state has persisted and he has remained under the care of his family for more than a year.

DISCUSSION

Confusion may be defined as the inability to maintain a logical train of thought or action with inattention and distractibility. These patients are disoriented and may exhibit paramnesia. They have marked difficulty writing, naming, and calculating and often are inappropriately jocular, speaking in a "military" or "legal" pattern.¹ Agitation, at times, is prominent.^{2,3,7-9}

Dementia denotes a clinical syndrome characterized by progressive deterioration of intellectual function, which impairs the patient's ability to adapt to the environment.^{10,11} The speed of onset, rate of evolution, and duration vary with the cause of the dementia and the patient, but deterioration is always progressive.¹² CCS is a static condition and is not characterized by a progressively deteriorating course.

In our patients, infarction in the distribution of the right middle cerebral artery produced a confusional state that persisted. Elementary focal signs appeared at the same time as the confusional state; they improved in one patient.

Impaired selective attention is present in all con-

fused patients. The definition of attention, as described by Mesulam, denotes two distinct processes. The tonic regulates the threshold which a stimulus must exceed before gaining access to consciousness; the second is phasic and selects from among the many stimuli which exceed this threshold. The tonic process of attention is closely related to the concept of arousal. The phasic process or selective attention is necessary for the production of a coherent stream of thought and for the maintenance of a coherent sequence of goal-oriented behavior.² The concept that the right hemisphere has a special role in attention and probably is dominant for this function has arisen from clinical observation experiments^{2,13-18} in normal people and those with unilateral brain damage^{13,19-21,25-29} and animal experimentation.^{13,16,30-37} The left hemisphere is dominant for many formal components of language,³⁴ but the right hemisphere is superior as far as the phenomena of attention, emotion, and complex nonverbal operations are concerned.^{13,14,19,39} There is a clear anatomical basis for the specialization of the left hemisphere in language, but the anatomical basis of the right hemispheric specialization is less well understood.

Although it is difficult to compare details of cerebral organization of other primates and humans, the types of unilateral neglect described in the macaque monkey also can be seen in human patients.¹³⁻¹⁹ This suggests that a similar pattern of organization may account for the coordination of directed attention in all primates.¹³ Right hemisphere lesions are the predominant cause of unilateral neglect syndromes. Right-sided neglect does follow lesions of the left hemisphere but this is rare and usually mild and short lived.^{15,40,41} The observation that universal neglect, or inattention, the essence of a confusional state, occurs with right hemispheric lesions supports the hypothesis that the right hemisphere has a dominant role in attentional mechanisms.^{1,2,13,19}

In the light of this discussion, the concept of multi-infarct dementia should be reviewed. This disease state represents a progressive diffuse dementia coupled with signs of focal cerebral pathology. The condition is progressive, evolving in a series of discrete episodes, during which focal neurologic dysfunction is evident on examination. These deficits usually resolve, but with each new event there is a deterioration in the intellectual functioning of the patient.⁴² Confusion, as described, is not seen. In the chronic confusional state, a fixed syndrome is seen which persists and is not progressive. A significant number of patients labeled as having multi-infarct dementia may be examples of the chronic confusional state resulting from a single right hemispheric infarction. ■

REFERENCES

1. Geschwind N: Disorders of attention. *Philos Trans R Soc Lond* 298:173-185, 1982.
2. Mesulam MM, Waxman SG, Geschwind N, Sabin TD: Acute confusional states with right middle cerebral artery infarctions. *J Neurol Neurosurg Psychiatry* 39:84-89, 1976.
3. Horenstein S, Chamberlain W, Conomy J: Infarction of the fusiform and calcarine regions: Agitated delirium and hemianopia. *Transactions Am Neuro Assoc* 92:85-89, 1967.
4. Medina JL, Rubino FA, Ross A: Agitated delirium caused by infarction of the hippocampal formation and fusiform and lingual gyri: A case report. *Neurology* 24:1181-1183, 1974.
5. Hyland HH: Thrombosis of intracranial arteries. *Arch Neuro Psychiatry* 30:342-356, 1933.
6. Amyes EW, Nielsen JM: Clinicopathologic study of vascular lesions of the anterior cingulate region. *Bull Neuro Soc* 20:112-130, 1955.
7. Lipowski ZJ: Delirium, clouding of consciousness, and confusion. *J Nerv Ment Dis* 145:227-253, 1967.
8. Chedra F, Geschwind N: Disorders of higher cortical functions. *Cortex* 8:395-411, 1972.
9. Adams RD, Victor M: Delirium and other acute confusional states (chap. 19), in *Principles of Neurology*. New York, NY, McGraw-Hill, 1981, p. 275-284.
10. Adams RD, Victor M: The dementias and Korsakoff's psychosis, in *Principles of Neurology*. New York, NY, McGraw-Hill, 1981, p. 285.
11. Wells C: *Dementia*. Philadelphia, PA, Davis, 1977.
12. Haase GR: Diseases presenting as dementia, in Wells C, *Dementia*. Philadelphia, PA, Davis, 1971, p. 164-205.
13. Mesulam MM: A cortical network for directed attention and unilateral neglect. *Ann Neuro* 10:309-325, 1981.
14. Critchley M: *The Parietal Lobes*. London, England, Edward Arnold, 1953.
15. Critchley M: The phenomenon of tactile inattention with reference to parietal lesions. *Brain* 72:538-561, 1949.
16. Denny-Brown D, Chambers RA: The parietal lobe and behavior. *Proc Assoc Res Nerv Ment Dis* 36:35-117, 1958.
17. Heilman KM, Valenstein E: Auditory neglect in man. *Arch Neurol* 26:32-35, 1972.
18. Heilman KM, Valenstein E: Frontal lobe neglect in man. *Neurology* 22:660-664, 1972.
19. Heilman KM, Van Den Abell T: Right hemisphere dominance for attention: The mechanism underlying hemispheric asymmetries of inattention. *Neurology* 30:327-330, 1980.
20. Anzola GP, Bertoloni G, Buchtel HA, Rizzolatti G: Spatial compatibility and anatomical factors in reaction times. *Neuropsychologia* 15:295-302, 1977.
21. DeRenzi E, Faglioni P, Scotti G: Hemispheric contribution to exploration of space through the visual and tactile modality. *Cortex* 6:191-203, 1970.
22. Desmedt JE: Active touch exploration of extrapersonal space elicits specific electrogenesis in the right cerebral hemisphere of intact right-handed man. *Proc Natl Acad Sci USA* 74:4037-4040, 1977.
23. Dimond SJ: Depletion of attentional capacity after total commissurotomy in man. *Brain* 99:347-356, 1976.
24. Dimond SJ: Tactual and auditory vigilance in split-brain man. *J Neurol Neurosurg Psychiatry* 42:70-74, 1979.
25. Gainotti G, Messerli P, Tissot R: Qualitative analysis of unilateral spatial neglect in relation to laterality of cerebral lesions. *J Neurol Neurosurg Psychiatry* 35:545-550, 1972.
26. Howes D, Boller F: Simple reaction time: Evidence for focal impairment from lesions of the right hemisphere. *Brain* 98:317-332, 1975.
27. Kimura D: The asymmetry of the human brain. *Sci Am* 228:70-78, 1973.
28. Oxbury JM, Campbell DC, Oxbury SM: Unilateral spatial neglect and impairments of spatial analysis and visual perception. *Brain* 97:551-564, 1974.
29. Schenkenberg PH, Pustman RE, Beck EC: Changes in evoked responses related to age, hemisphere, and sex. *Electroencephalogr Clin Neurophysiol* 30:163, 1971.
30. Heilman KM, Pandya DN, Geschwind N: Trimodal inattention following parietal lobe ablations. *Trans Am Neurol Assoc* 95:250-261, 1970.
31. Hyvarinen J, Poranen A: Function of the parietal association area 7 as revealed from cellular discharges in alert monkeys. *Brain* 97:673-692, 1974.
32. Jansen J, Anderson P, Kaada BP: Subcortical mechanisms in the "searching" or "attention" response elicited by prefrontal cortical stimulation in unanesthetized cats. *Yale J Biol Med*, 28:331-341, 1955.
33. Kennard MA: Alterations in response to visual stimuli following lesions of frontal lobe in monkeys. *Arch Neurol Psychiatry* 41:1153-1165, 1939.
34. Lamotte RH, Acuna C: Defects in accuracy of reaching after removal of posterior parietal cortex in monkeys. *Brain Res* 139:309-326, 1978.
35. Mountcastle VB, Lynch JC, Georgopoulos A, et al.: Posterior parietal association cortex of the monkey: Command functions for operations within extrapersonal space. *J Neurophysiol* 38:875-908, 1975.
36. Watson RT, Heilman KM, Cauthen JC, King FA: Neglect after cingulectomy. *Neurology* 23:1003-1007, 1973.
37. Welch K, Stuteville: Experimental production of unilateral neglect in monkeys. *Brain* 81:341-347, 1958.
38. Geschwind N: Disconnection syndromes in animals and man. *Brain* 88:237-294, 585-644, 1965.
39. Heilman KM, Schwarz HD, Watson RT: Hypoarousal in patients with the neglect syndrome and emotional indifference. *Neurology* 28:229-232, 1978.
40. Battersby WS, Bender MB, Pollack M, Kahn RL: Unilateral "spatial agnosia" (inattention) in patients with cerebral lesions. *Brain* 79:68-93, 1956.
41. Leceister J, Sidman M, Stoddard LT, Mohr JP: Some determinants of visual neglect. *J Neurol Neurosurg Psychiatry*, 32:580-587, 1969.
42. Hachinski VC, Lassen NA, Marshall J: Multi-infarct dementia: A cause of mental deterioration in the elderly. *Lancet* 2:207, 1974.

The Physician and Patient

The following letters were submitted by Richard Fadil, MD, of Clifton. We commend Dr. Fadil for permission to publish these illustrative and educational letters, and for recognizing an area in which physicians can improve relations with patients.

Dear Dr. Fadil:

In July and August, my father was hospitalized in your care for a TURP. As you may recall, the expected routine recovery was complicated by persistent bleeding, bladder spasms, and hyponatremia. The latter led to hallucination, combativeness, and other cognitive disturbances. Fortunately, the problem was identified and resolved completely. We are convinced that he received the best possible surgical care and that his complications were in no way related to the care he received from you in the operating room. I want to make that clear.

But I felt obligated to write you—without my father's knowledge—so that you know I am distressed by some aspects of treatment, and that he shares these feelings with me, even if he doesn't verbalize them.

Dr. Fadil, when my father was in the hospital, he complained to me and my mother about two things: the severity of the pain from the bladder spasms, which led to him asking for a private nurse one night, and the fact that he always felt you were in a big hurry to get out of the room when you came to visit him.

I understand what he means. The two times I spoke with you—at the moment of acute episodes in his hospital stay—you seemed reluctant to offer explanations, reassurances, or your time for more than a second. I felt like an attorney interrogating a hostile witness. My father said something to the effect of "I wanted to ask him such-and-such, but he seemed in such a hurry" or "It was like he couldn't wait to leave."

Dr. Fadil, I wish you had given him—and me—the benefit of a moment of "I'm here for you to talk if you want." I know that when I saw you at your office

it was between office patients, and you were wedging in time for me—that's fine, a few minutes was all I needed. But in my father's eyes you are a powerful source of healing, and even with Dr. Jaffe making rounds, my father still held you in the highest authority and ability.

If my father hadn't voiced these concerns to me, I don't think I'd be writing. But he is such a stoic that something really has to bother him for it to take the form of words.

I can't offer you advice on how to perform surgery—the esteem in which people hold you tells me you are gifted and well practiced. But from the human side—I think I saw something that I can tell you. Please make your patients feel that your handiwork doesn't stop after the anesthesia wears off. I'd go so far as to say that the need to attend to many patients doesn't outweigh the need to make each one feel special and cared for. Nursing care is no substitute for the power of the physician's role in healing; you should know that people invest a lot of trust in you, and really draw on your strengths to get well. That's the best way I can put it: Stroke your patients more, psychologically.

I'm not trying to be arrogant. But I found myself needing to be my father's personal patient advocate. I hope you read this letter in that spirit. Good luck, and continue healing for many years.

Dear John:

The tenderness in your letter does not permit me to use business form.

Since its receipt, I have taken pause and have tried to come closer to the perfection the letter and my profession preach. It will be at my right elbow for some time that I may read it and, thus, remind myself intermittently.

The subject is a most complex one. And probably one that we, in my profession, as well as in our society, should savor, deliberate, articulate, and reinforce with each other. It flows from the Golden Rule. It is most powerful. My sincere thanks for your letter. ■

PTCA in Anomalous Coronary Artery

RICHARD D. GOULAH, MD
JONATHAN E. GOLDSTEIN, MD
JACOB I. HAFT, MD

A significant coronary artery lesion in a congenitally anomalous right coronary artery (RCA) was dilated successfully using percutaneous transluminal coronary angioplasty (PTCA). The anomalous coronary artery did not react any differently than an anatomically normal coronary artery.

Percutaneous transluminal coronary angioplasty (PTCA) is accepted as a means of dilating a severely stenotic coronary artery without subjecting the patient to thoracotomy.¹ PTCA has been reported widely in anatomically normal yet diseased vessels, but in few patients with congenitally abnormal coronary arteries.²⁻⁵ This report describes successful angioplasty of a severely narrowed segment of a congenitally anomalous right coronary artery.

A 58-year-old white male busdriver with no past history of diabetes mellitus, hypertension, rheumatic fever, murmurs, or myocardial infarction, was in his usual state of health until April 1986, when he developed retrosternal chest pressure radiating to both arms and to the jaw with diaphoresis that occurred with exertion; this lasted five to ten minutes and was relieved with rest. Subsequently, the pain also was precipitated by cold and by emotional

upset. He denied shortness of breath or other signs of heart failure. The patient initially was treated with sublingual nitroglycerin and later was given Diltiazem® 30 mg once a day, Isordil® 5 mg once a day, Xanax® 0.5 mg three times a day, and Zantac® 150 mg twice a day (for history of hiatal hernia). A stress test performed ten days prior to admission was positive at four minutes with severe chest pain. Because his chest pain persisted and was not relieved with rest or nitroglycerin, he immediately was admitted to the coronary care unit where myocardial infarction was ruled out. Six days later, the patient was transferred to Saint Michael's Medical Center for coronary arteriography. Risk factors included smoking two packs of cigarettes per day for ten years and a family history of heart disease—his twin brother had a myocardial infarction. The patient had abused alcohol in the past but had not been drinking for eight years. Physical examination was unremarkable with no abnormal findings. Electrocardiogram showed normal sinus rhythm and non-specific ST&T wave changes.

Coronary arteriography revealed 95 percent stenosis of the first diagonal branch of the left anterior

Drs. Goulah, Goldstein, and Haft are affiliated with Saint Michael's Medical Center. Requests for reprints may be addressed to Dr. Haft, Saint Michael's Medical Center, 268 Martin Luther King Jr. Blvd., Newark, NJ 07102.

CASE REPORT

descending (LAD) and minimal intraluminal disease of a short diminutive left circumflex (LCX). The right coronary artery (RCA) originated in the usual location in the anterior portion of the right coronary sinus; however, shortly after its origin, it gave rise to a large anomalous branch that coursed posterior to the aorta. The remainder of the right coronary artery in the right ventricular arteriovenous (AV) groove was small and did not go to the crux of the heart, tapering to its end before the origin of the posterior descending artery (PDA). The anomalous branch continued posterior to the aorta to the posterior left ventricular wall, replacing the distal left circumflex and feeding two large posterior lateral vessels and the posterior descending artery. There was a severe subtotal occlusion in the anomalous vessel just proximal to the take off of the two

large posterolateral arteries and before the large posterior descending artery. These branches were free of luminal irregularity. Left ventriculogram showed mild antero-apical hypokinesis.

The patient tolerated the procedure well and was started on Persantine[®] 75 mg every eight hours, and continued on Isordil[®] 5 mg once a day. Cardizem[®] was increased to 60 mg every eight hours.

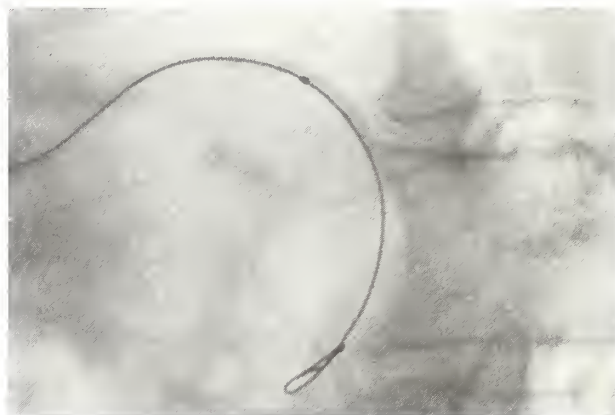


Figure 1C. The balloon is positioned and inflated in the area of severe stenosis.

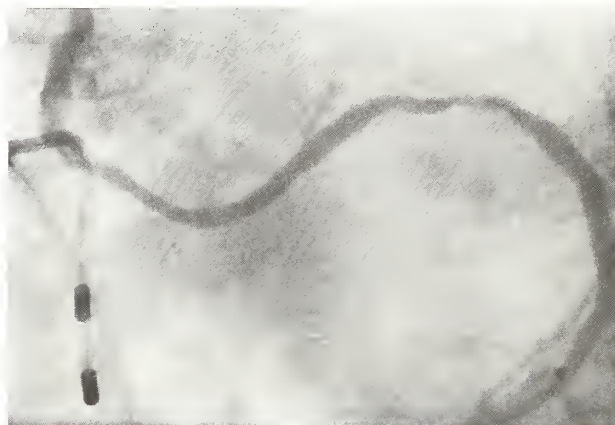


Figure 1D. The postangioplasty arteriogram (LAO projection) shows successful opening of the stenosis.

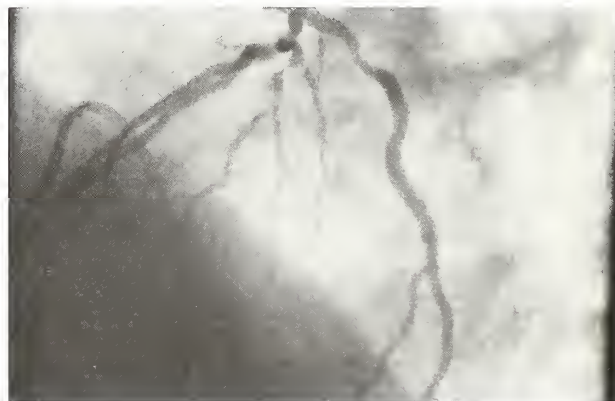


Figure 2. Injection of the left coronary artery in the LAO projection; panel A is prior to angioplasty of the subtotally occluded diagonal artery and panel B is after successful dilatation of the vessel. Note the large obtuse marginal (or first lateral) branch of the LCA that goes posteriorly.



Figure 1A. Injection of the ostium of the RCA in the LAO (A) and RAO (B) projections. Shortly after the origin of the RCA, there is a large anomalous branch that goes posterior to the aorta, abruptly bends, courses in the posterior left AV groove and becomes the LCF giving off two laterals and then the posterior descending artery. The obtuse marginal (or first lateral) is a branch of the main left coronary (Figure 2). There is a subtotal occlusion of the anomalous artery at its bend point when it enters the posterior left AV groove, and a minor narrowing near its origin.

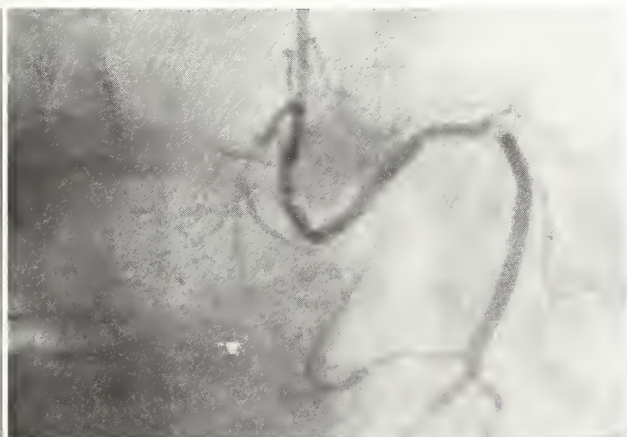


Figure 1B. The RCA is seen to course in the RV AV groove and to be nondominant. The injection in 1A was almost selective into the anomalous branch.

Five days later, PTCA of the anomalous right coronary artery and the diagonal branch of the LAD was accomplished successfully without difficulty using a .016 floppy guiding wire and 2.5 and 3.5 mm balloons. Approximately ten minutes after successful dilatation of the RCA while still in the catheterization laboratory, the patient developed spasm with total occlusion in the area of the dilated RCA. He was given sublingual procordia, aspirin, and an additional 5,000 units heparin. Subsequently, the lesion remained open. The patient was transferred back to CCU in stable condition and was started on a heparin drip. He did well and was transferred to the floor the following day and started on Coumadin®. He was discharged to his home on hospital day five, and has remained angina-free on Procordia® 10 mg once a day, Persantine® 75 mg every eight hours, aspirin grain 5 twice a day, Isordil® 5 mg three times a day, Coumadin® 5 mg once a day, and Zantac® 150 mg twice a day.

Percutaneous transluminal coronary angioplasty is an important therapeutic modality in the management of coronary artery disease. Primary success is achieved in about 90 percent of patients, although approximately 30 percent of the initially successful procedures fail to stay open for extended periods and require redilatation.^{1,6} Multiple vessel PTCA has been similarly successful. As yet, there have been few reports of successful angioplasty of an anomalous coronary artery.²⁻⁵ This case demonstrated multiple PTCA in a patient who also required dilation of an anomalous RCA artery.

Congenital anomalies of the origin of a major coronary artery occur rarely.⁷ Chaitman et al. found 31 cases among 3,750 patients undergoing coronary arteriography.⁸ Abnormalities of the origin of the left circumflex artery from the right sinus of Valsalva or as a branch of the RCA are among the most common of these anomalies, occurring in 20 of 2,996 patients undergoing arteriography as reported by Page and

colleagues,⁹ in 17 of the 31 patients reported by Chaitman et al.,⁸ and in 14 of 224 coronary anomalies reported by Ogden.¹⁰ Roberts reported 15 patients, 22 to 71 years old, with this abnormality.⁷ In about half the patients, the LCX is a branch of the RCA; the other patients have a separate LCX orifice in the right coronary cusp.⁹

The atherosclerotic lesions in this patient appeared readily accessible to angioplasty and, as expected, PTCA was accomplished with no extraordinary difficulty. The occurrence of spasm in the area and the localization of the lesion in the site of connection between the anomalous RCA and what appeared to be a distal LCX is of interest. The abnormal positioning and origin of the vessel may have played an etiological role in the development of the atherosclerotic lesion because the site was at an area that would have been expected to have increased mural trauma and turbulence. Occlusive atherosclerotic lesions have been reported to occur in anomalous LCX coronary arteries by others⁹ but specific localization in the vessel has not been discussed.

Successful PTCA of stenotic lesions in anomalous coronary vessels has been reported in five patients. In three patients, the dilated artery was a circumflex that originated as a branch of the right coronary artery⁴ (as in our patient) or from a separate ostium in the right coronary cusp.^{2,3} In all three patients, the anomalous vessel coursed behind the aorta and had its lesion near the point of connection between the retro aortic portion and the "normal" part of the LCF supporting the possibility that abnormal turbulence may have contributed to development of the lesions. The other abnormal vessels included a left main originating from the right sinus of Valsalva with a lesion in its LAD branch³ and a single coronary originating from the left coronary cusp with a lesion in the LCX branch.⁵ Balloon dilatation was reported successful in all instances. ■

REFERENCES

1. Gruntzig AR, Senning A, Siegenthaler WE: Non-operative dilatation of coronary artery stenosis. *N Engl J Med* 301:61, 1979.
2. Schwartz L, Aldridge HE, Searle C, Csepio R: Percutaneous transluminal angioplasty of an anomalous left circumflex coronary artery arising from the right sinus of Valsalva. *Cathet Cardiovasc Diag* 8:623, 1982.
3. Bass TA, Miller AB, Rubin MR: Transluminal angioplasty of anomalous coronary arteries. *Am Heart J* 112:610, 1986.
4. Kimbiris D, Lo E, Iskandrian A: Percutaneous transluminal coronary angioplasty of anomalous left circumflex artery. *Cathet Cardiovasc Diag* 13:407, 1987.
5. Medina A, Bethencourt A, Coello I, et al.: Angioplastia transluminal coronaria en un paciente con sistema coronario unico. *Revista Espanola Cardiol* 40:289, 1987.
6. Hirzel HO, Eichhorn P, Kappenberger L, et al.: Percutaneous transluminal coronary angioplasty: Late results at five years following intervention. *Am Heart J* 109:575, 1985.
7. Roberts WC: Major abnormalities of coronary arterial origin seen in adulthood. *Am Heart J* 111:941, 1986.
8. Chaitman BR, Lesperance J, Saltiel J, Bourassa MG: Clinical, angiographic, and hemodynamic findings in patients with anomalous origin of the coronary arteries. *Circulation* 53:122, 1976.
9. Page HL, Engel HJ, Campbell WB, Thomas CS: Anomalous origin of the left circumflex coronary artery. *Circulation* 50:768, 1974.
10. Ogden JA: Congenital anomalies of the coronary arteries. *Am J Cardiol* 25:474, 1970.

Financing Medical Education

JOSEPH A. LIEBERMAN, III, MD
CYNTHIA BARANSKI, RN

As more health care services are being diverted from hospitals to the ambulatory setting, funding for student and resident training in this setting becomes a problem. This paper details the causes of this problem and proposes some financial solutions.

In an article in the *Journal of the American Medical Association*, Gerald T. Perkoff, MD, made a reasonable and impassioned plea to change the way with which the American medical education establishment deals with the issue of financing graduate medical education.¹ We support his contentions and embrace his logic. We do not think he went far enough, nor was he specific enough in his recommendations.

Dr. Lieberman is professor and chairman, Department of Family Medicine, UMDNJ-Robert Wood Johnson Medical School, and Ms. Baranski is an endoscopy nurse, UMDNJ-Robert Wood Johnson University Hospital. Requests for reprints may be addressed to Dr. Lieberman, UMDNJ-Robert Wood Johnson Medical School, 1 Robert Wood Johnson Place, CN 19, New Brunswick, NJ 08903-0019.

Ambulatory care services have been a low priority in medical education due to the associated financial burden.² Many patients serviced in the traditional outpatient clinic setting have inadequate or no health insurance, or are covered only by Medicaid or Medicare. Yet, there is an increasing consensus that ambulatory care must play a greater role in undergraduate and graduate medical education as ambulatory care is playing a greater part in the health care industry. Patients are being discharged from the hospital as soon as possible; therefore, there is less time for medical students and residents to learn from these patients. In addition, it is recognized that ambulatory care is an important way of providing comprehensive services to patients as well as a means of keeping health care costs down. This trend has led to an increased demand for physicians



Figure. Aerial photograph of Robert Wood Johnson University Hospital. © Roy W. Jones

trained in the primary and ambulatory care setting. These factors have made the training of residents in the ambulatory care setting an important part of medical education.³

With the hospitalized patient, additional charges associated with medical education almost universally are absorbed as part of the hospital bill and are paid by third-party payers. It is a form of "tax" for medical education that applies to the approximately 85 percent of the New Jersey population that has insurance coverage for hospitalization. In this way, individuals utilizing the hospital and receiving services of physicians-in-training also are bearing the costs as part of the hospitalization. Of course, much of the controversy swirls around the issue of service. When does a learner's educational experience become a provider's service? It is reasonable to assume that a resident's first arterial puncture may be largely construed to be a learning experience (although there is a service component) and likewise, the 100th arterial puncture by the same individual could be largely construed to be service (with less of an educational component). But when did this transition occur? We contend that it virtually is impossible to differentiate the educational from the service components of a resident's experience and, therefore, the point is moot. The reality is the activity is performed and, regardless of intent, it should be properly compensated. At present, this is not an issue for hospitalized patients as payment, for resident's services are part of the cost of providing health care to the hospitalized patient.

However, an altogether different set of rules applies in the outpatient area, as the cost of outpatient medical education traditionally has not been part of the fee paid for medical care received in that area. Nonetheless, expenses accompany education regardless of setting and, therefore, we will find ourselves with an increasing responsibility to fund such education as more and more of medical education is shifted to the ambulatory care area.

It has been felt by some in the medical education community that the government should help supplement funding for medical training since it serves the public good. However, the present administration has championed a decreased role for the government in the private sector, and any new administration must wrestle with the issue of the budget deficit. Therefore, it would appear that the medical education community cannot rely on government funding and must look to alternative resources to fund training.⁴

We would submit, in addition to patients, there are other groups that benefit from the product of medical education and are in a position to assist in the financing of the ambulatory care portion of a medical education program.

Faculty Practice Plans. These are plans whereby members of a medical school faculty receive compensation for the health care services they provide in the course of their day-to-day clinical and teaching activities. These monies have largely accrued to the benefit of the faculty and little have returned to the medical education system. However, many fac-

ulty members derive their faculty practice components from the patient population referred to them by primary care physicians or from the ambulatory area. Inasmuch as most of these faculty members already have a base salary supported by the state or the university for the teaching activities in which they are engaged, it only seems reasonable that some of the clinical monies they earn in addition to this salary could be diverted for purposes of supporting the teaching in the ambulatory area. A show of support would help solidify the concept of "faculty" and demonstrate a willingness to work collectively toward the common good.

Practicing Physicians. Perkoff eloquently points out that there has been a tradition in other professions of paying for the education of junior members of the profession. Law clerks are one example, but other fields such as engineering and architecture also have such traditions.¹ It would seem reasonable that practicing physicians, who eventually will be benefiting from the talents brought to their fields by these young physicians, should be involved in financing the training of these young professionals. Perhaps an expanded hospital staff dues program could be used to this end or some consideration could be given to a bed tax or some other equitable system of collection. After all, the bulk of ambulatory care is provided in facilities which are the financial responsibility of the provider, whereas, secondary and tertiary services largely are delivered in facilities provided, and supported, by the community at virtually no cost to the provider. It seems reasonable that those individuals who benefit from the use of the tertiary care institutions with the "learners" and patients contained therein should make a contribution of money as well as service to the institutions. In turn, this would be used to provide some of the financial underpinnings for the training of those physicians who ultimately will provide these patients to the institution.

The Health Insurance Industry. The health insurance industry benefits from the labors of its physician participants. Certain programs particularly have done well by judiciously avoiding any hospital in which there is a surcharge added for medical education. These insurance plans purposely have sought out those institutions that have lower charges for patient care services because it puts them in a

better economic position in the marketplace. We would submit that there is an obligation for those individuals who benefit from the system to help support it, or at the very least, certainly not subvert it by choosing institutions that are not financially penalized by being involved in the education of the next generation of "providers" for the insurance company. We propose a pool of money be established, provided by the insurance industry, which then would be allocated for medical education in the ambulatory area and, as a result, would spread this burden across all insurance companies and hospitals. Certainly, precedent has been set in New Jersey with the development of a pool of money to support the provision of hospital care for the indigent. Given the equally laudable nature of this educational undertaking, application of this same strategy seems appropriate.

A greater understanding of the need to improve and finance training of students and residents in ambulatory care is needed to help make the health-care community respond to changes in the organization and financing of medical training. In addition, the increase in "cost containment" and the fact that more hospitals are operating in the "red," are forcing the cost of medical education to become a shared responsibility for the health care community.

The groups named in this paper appear to be viable resources to help resolve the financial part of this problem: they have the financial resources, they could benefit from the plan, and they have a vested interest in improving health care education.

CONCLUSION

The lack of adequate training programs in the area of ambulatory care should serve as an impetus for the medical care and educational communities to find resources to fund the training of physicians in this area of health care. Due to the high cost of this training, funding cannot come from only a single source; that is, we no longer can rely solely on government funding. Income from patient care revenue is not able to totally support the added overhead cost of educational programs in ambulatory care. The health care community has a responsibility to provide trained physicians to care for the changing health care needs of society. Alternative financial resources must be sought if we are going to continue educating our physicians. ■

REFERENCES

1. Perkoff GT: Graduate medical education confronted. *JAMA* 259:402-404, 1988.
2. Rothstein WG: Graduate medical education, in *American Medical Schools and the Practice of Medicine*. New York, NY, Oxford University Press, 1987, p. 274.
3. Perkoff GT: Teaching clinical medicine in the am-

bulatory setting: An idea whose time may have finally come. *N Engl J Med* 314:27, 1986.

4. Nash DB, Williams SV: Graduate medical education; who will pay how much for what? *Ann Intern Med* 106:323, 1987.

Ammonia Encephalopathy

STEVEN PELTZ, MD
SOPHIA SCHWARTZMAN, MD
BARRY COHEN, MD

Ureterosigmoidostomy can be complicated by pyelonephritis, renal calculi, hypokalemic hyperchloremic acidosis, and colonic neoplasia. It has been associated with the development of hyperammonemia and encephalopathy in patients with underlying liver disease. We report a rare case of hyperammonemic encephalopathy in a patient with normal liver function.

A 69-year-old white female was admitted to the hospital with confusion and increasing lethargy. Bladder cancer had been diagnosed 20 years earlier and ureterosigmoidostomy performed. The patient did well following surgery, although she was known to have hyperchloremic metabolic acidosis, which was treated with sodium bicarbonate.

Two months prior, the patient was admitted to the hospital with fever, vomiting, and dehydration. During the hospital stay, blood cultures grew *E. coli* and she responded to intravenous antibiotics and fluids. However, the patient developed a generalized tonic-clonic seizure 48 hours after admission. Neurologic evaluation was obtained. Both computed tomog-

raphy (CT) scan and magnetic resonance imaging (MRI) of the head failed to show focal abnormalities. Electroencephalogram showed diffuse, slow-wave activity suggestive of generalized cerebral dysfunction, as seen with cerebral edema, encephalopathy, or a postictal state. The patient was considered to have an idiopathic seizure disorder. She was treated with oral phenytoin; she was discharged in improved condition.

Present physical examination showed the patient to be confused and lethargic, with a temperature of 100.1°F and nonlabored respirations. Neurologic examination showed a supple neck, increased tone in the upper and lower extremities, exaggerated deep tendon reflexes, and bilateral positive Babinski's sign. Serum sodium was 154 mEq/L; potassium 3.8 mEq/L; chloride 125 mEq/L; carbon dioxide 12 mEq/L; arterial pH 7.35; and magnesium 2.1 mg/dl. Blood cultures yielded no growth. A lumbar puncture showed colorless fluid with no white or red cells. The cerebrospinal fluid protein was 41 mg/dl and glucose was 58 mg/dl. Plasma ammonia level was

Drs. Peltz and Schwartzman are associated with the Trenton Affiliated Hospitals Residency Program, Helene Fuld Medical Center, Trenton. Dr. Cohen is chief, Department of Nephrology, Helene Fuld Medical Center. Requests for reprints may be addressed to Dr. Peltz, Department of Medicine, Helene Fuld Medical Center, 750 Brunswick Avenue, Trenton, NJ 08638.

CASE REPORT

138 $\mu\text{mol/L}$ (normal 12-50 $\mu\text{mol/L}$) and a CT scan of the head revealed no focal abnormalities. Electroencephalogram on the second hospital day was consistent with severe generalized cerebral dysfunction, such as seen with metabolic or infectious processes.

Intravenous hydration and antibiotics were administered. The patient, however, remained comatose and was observed to have a generalized tonic-clonic seizure despite treatment with phenytoin. Repeat plasma ammonia level was 253 $\mu\text{mol/L}$. She was treated with oral lactulose and the blood ammonia level gradually decreased to 60 $\mu\text{mol/L}$ over the next seven days, with marked neurologic improvement.

Her liver function tests showed no abnormalities. Liver-spleen scan showed no space-occupying lesions or marginal irregularities. Renal ultrasound showed atrophy of the right kidney and a slightly enlarged left kidney with a small cyst and a possible stone. The patient was discharged on oral lactulose, phenytoin, and sodium bicarbonate. After a few months she became confused and lethargic. Arterial ammonia level again was elevated and treatment with a rectal tube was initiated. The tube was inserted by the patient at bedtime and removed upon awakening. It was anticipated that the rectal tube would

aid in the evacuation of urine and feces that collected in the patient's "sigmoidal bladder" while she slept.

The rectal tube has proved very efficacious. Since beginning use of the rectal tube five months ago, the 69-year-old patient has manifested normal mental status with normal arterial ammonia levels.

DISCUSSION

Ammonia encephalopathy, also known as hepatic encephalopathy, is a well-known but poorly understood neuropsychiatric syndrome frequently seen in patients with severe liver disease, with or without portal-systemic shunting of blood. Although the pathogenesis of hepatic encephalopathy remains obscure, and various "toxins" have been implicated to play a role, it is well known that elevated blood ammonia level is associated closely with hepatic encephalopathy, though it certainly is not the only cause.¹

Ammonia is formed in the gastrointestinal tract from nitrogenous substances by bacterial urease and amino acid oxidases (deaminase). The colon is the most important region of ureolysis because the number of microorganisms with urease activity are greatest there and decrease in the ileum and are few

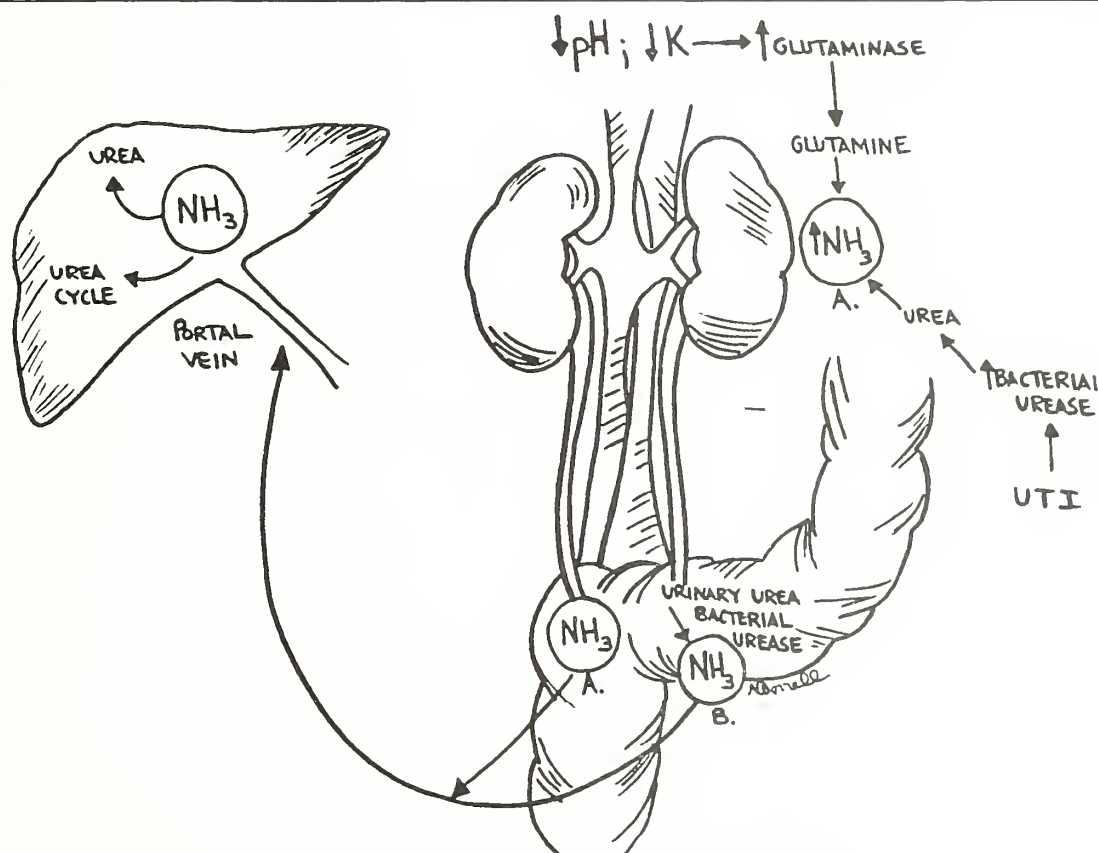


Figure. A = Urinary ammonia; B = Ammonia produced in the colon by the action of urease on urinary urea.

CASE REPORT

or absent at more proximal locations.² A substantial quantity of ammonia also is derived from intestinal glutamine with some contribution from the kidney and muscle (via intracellular catabolism of amino acid and muscle adenine). Further elevation of ammonia can result from diversion of the urinary stream to the intact colon, e.g. ureterosigmoidostomy.

Mortensen,¹ Egense and Schwartz,³ Legrain,⁴ and Silberman⁵ reported cases of encephalopathy with hyperammonemia resulting as a complication of ureterosigmoidostomy in patients with liver impairment or known hepatic cirrhosis. Mounger and Branson⁶ and Kaufman⁷ cited similar cases; however, their patients had normal liver function and the latter had a normal liver biopsy. In these cases, the hyperammonemia is attributed to hepatic overloading by high ammonia levels in the portal return from the colon caused by absorption of urinary ammonia, or of ammonia produced by intracolonic bacterial hydrolysis of urinary urea, or both.⁸ Urinary ammonia production is increased in conditions of systemic acidosis, hypokalemia, and bacterial infection.⁵ The first two conditions stimulate glutaminase activity in the distal renal tubule cells, with the resultant breakdown of glutamine to ammonia. It follows that any condition causing colonic stasis with resultant urine pooling, e.g. constipation, would be expected to increase ammonia levels by the two mechanisms.

Egense and Schwartz³ and Mortensen,¹ simulated a constipated state by balloon tamponade of the rectum, in patients with ureterosigmoidostomies and known liver impairment. They noticed this produced a rise in blood urea and ammonia with the development of encephalopathy which was reversible by removal of the tamponade and by administration of antibiotics. Imler and others, aware of

these tamponade experiments, sought to test and verify that overloading of normal ureagenesis by an increased portal ammonia supply was possible, even in patients with normal liver function.⁹ They performed ureterocolostomies in rats and noted that these rats had chronic but moderate systemic hyperammonemia without any histologic evidence of hepatic damage. Kaufman cited two intriguing cases of hyperammonemic encephalopathy caused by urinary obstruction and infection in patients without demonstrable liver dysfunction.^{7,10,11} It is thought that hyperammonemia was caused by bacterial hydrolysis in the stagnant urine of a distended urinary bladder. It is easy to see how a sigmoidal bladder, with its greater surface area and greater concentration of urease-producing bacteria, could create the same state, perhaps more easily.

We believe our patient experienced ammonia encephalopathy. Our patient did well for 20 years following ureterosigmoidostomy before developing mental changes and seizures. In the patients of Mounger and Branson⁶ and Kaufman,⁷ 26 years and 40 years, respectively, were the time intervals for the development of neurologic symptoms including seizures. Severe electrolyte imbalance with dehydration, probable pyelonephritis, and urinary pooling in a sigmoidal bladder were the factors most responsible for precipitating ammonia encephalopathy in our patient. Despite having a therapeutic serum phenytoin level, breakthrough seizures continued during her hospital stay. Only after receiving a course of antibiotics, with fluid and electrolyte correction, and initiation of lactulose, did her serum ammonia level return to normal, and her confusional state resolve with cessation of seizures. Initiation of a nightly rectal tube, by decreasing urinary pooling time, has maintained the serum ammonia level within normal limits. ■

REFERENCES

1. Mortensen E, Lyn G, Juhl E: Ammonia-induced coma after ureterosigmoidostomy. *Lancet* 1:496, 1024, 1972.
2. Wolpert E, Phillips SF, Summerskill WHJ: Transport of urea and ammonia production in the human colon. *Lancet* 2:1387-1390, 1971.
3. Egense J, Schwartz M: Recurrent hepatic coma following ureterosigmoidostomy. *Scand J Gastroenterol Suppl* 7:149, 1970.
4. Legrain M, Baguet JC, LaPlane D: Coma hepatique mortel apres anastomose ureterocolique. *Presse Med* 75:749, 1967.
5. Silberman R: Ammonia intoxication following ureterosigmoidostomy in a patient with liver disease. *Lancet* 1:937-939, 1958.
6. Mounger EJ, Branson AD: Ammonia encephalopathy secondary to ureterosigmoidostomy: A case report. *J Urol* 108:411, 1972.
7. Kaufman JJ: Ammoniogenic coma following ureterosigmoidostomy. *J Urol* 131:743-745, 1984.
8. Amborse SS: Ureterosigmoidostomy, in: Glenn JF (ed), *Urologic Surgery*. Philadelphia, PA, J.B. Lippincott Company, 1983.
9. Imler M, Schlienger JL, Batzenschlager A: Hyperammonemia following ureterocolostomy in the rat. *Surg Gynecol Obstet* 149:183-188, 1979.
10. Drayna CJ, Titcomb CP, Varma RR, Soergel KH: Hyperammonemic encephalopathy caused by infection in a neurogenic bladder. *N Engl J Med* 304:766-768, 1981.
11. Ullman MA, Haecker TA, Medani CR: Hyperammonemic encephalopathy and urinary obstruction. *N Engl J Med* 304:1546, 1981.
12. Duckett JW, Gazek JM: Complications of ureterosigmoidostomy. *Urol Clin North Am* 10:473-481, 1983.
13. Goodwin WE, Scardino PT: Ureterosigmoidostomy. *J Urol* 118:169-174, 1977.

Idiopathic Unilateral Hyperlucent Lung

HEMANT PATEL, MD
MONROE S. KARETZKY, MD

The entity of unilateral hyperlucent lung in the adult is presented as a disease which has its origins in childhood and carries the potential for cardiopulmonary morbidity.

In 1953, Swyer and James reported the first case of a unilateral hyperlucent lung with diminished caliber of the ipsilateral pulmonary artery, as demonstrated by angiography, in a six-year-old boy with recurrent bronchitis. They termed the case, unilateral pulmonary emphysema.^{1,3} One year later, Macleod reported nine similar cases;⁴ hence, this entity is called the Swyer-James-Macleod syndrome.^{5,8} Following these two reports, many cases have appeared in the medical literature under different names, such as: unilateral hyperlucent lung,^{9,10} idiopathic unilateral hyperlucent lung,¹¹ unilateral lung transradiancy,¹² and chronic obstructive pseudoemphysema.¹³

We are reporting an additional case in a 42-year-old black female, with a review of the literature and an analysis of the associated characteristics of gas exchange and hemodynamics at rest and during exercise.

Drs. Patel and Karetzky are affiliated with the Department of Pulmonary Medicine, East Orange V.A. Medical Center and Newark Beth Israel Medical Center. Requests for reprints may be addressed to Dr. Karetzky, Newark Beth Israel Medical Center, 201 Lyons Avenue, Newark, NJ 07102.

CASE REPORT

A 42-year-old black female schoolteacher was admitted to the hospital because of cough and syncope. The patient was well until three days prior to admission, when she developed a sore throat, weakness, chills, and fever of 101°F. A cough was productive of white sputum but there was no reported hemoptysis, chest pain, shortness of breath, palpitations, or vertigo. She treated herself with an antitussive and one penicillin tablet. On the day of admission, she felt dizzy and collapsed. She had another episode of syncope in the emergency room.

The patient gave a history of recurrent pneumonia in childhood following the aspiration of a thumbtack at the age of seven years. She was a nonsmoker and denied previous episodes of loss of consciousness or of alcohol or drug abuse. Physical examination revealed a well-developed and well-nourished woman in no acute distress with stable and normal vital signs. Abnormal findings were limited to the chest which, on auscultation, revealed diminished breath sounds and diffuse rhonchi over the left hemithorax. An arterial blood gas sample showed Hb 12.1 gm/dl, pH 7.43, P_{CO_2} 38 mmHg, P_{O_2} 81 mmHg, and Hb_{O₂} 95 percent while breathing room air. The white blood

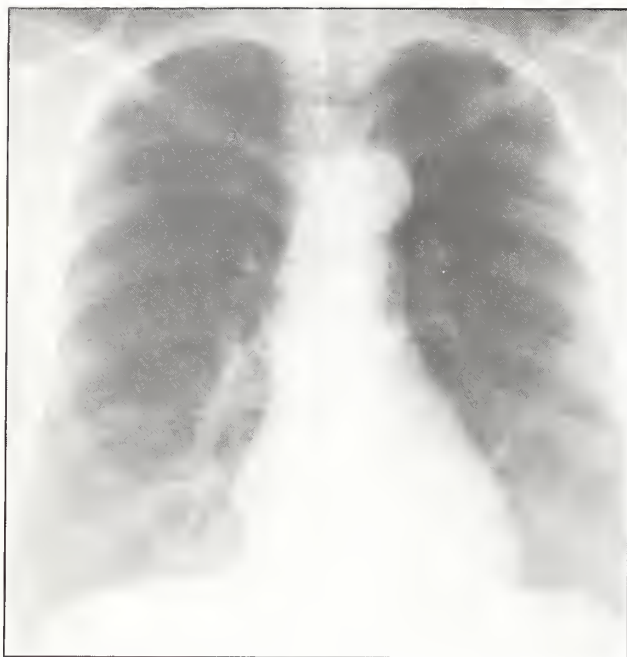


Figure 1. Chest x-ray showing decreased size of left hemithorax with increased lucency of left lung.

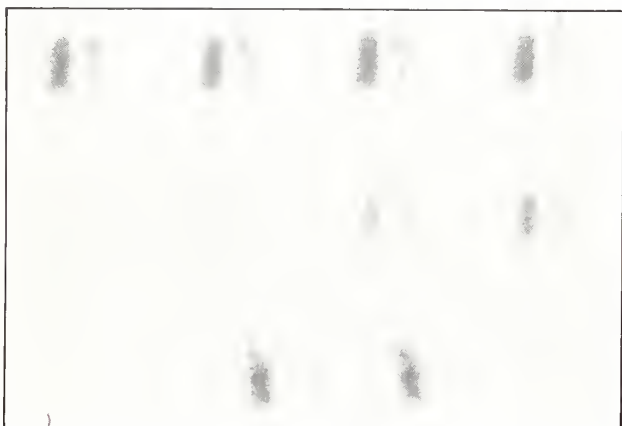


Figure 2. Nuclear ventilation scan using xenon-133 gas showing delayed filling and emptying of the left lung, indicating airway obstruction with gas trapping.



Figure 3. Perfusion scan using Tc 99 metastable macroaggregated albumin showing greatly diminished distribution of blood flow to left lung.



Figure 4. Computed tomography scan of the chest showing decreased vascular markings and size of left lung.

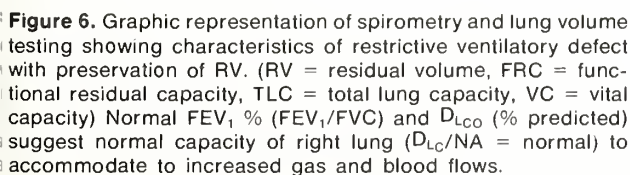
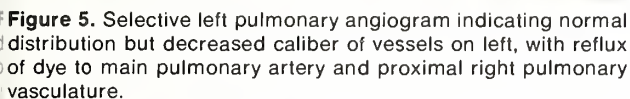
count, urine analysis, blood chemistries, and electrocardiogram were normal. The chest x-ray displayed decreased vascularity with hyperlucency of the left lung (Figure 1). A ventilation (Figure 2) and perfusion scan (Figure 3) showed greatly diminished ventilation and perfusion to the left lung. Computed tomography (CT) scan of the chest showed the left lung to have no evidence of bullous disease or bronchiectasis (Figure 4). Pulmonary angiography showed the left main pulmonary artery to be unobstructed but diminished in caliber with hypoperfusion of the left lung (Figure 5). The mean pulmonary artery pressure at rest was 16 mmHg. A multiple gated acquisition (MUGA) scan showed normal right (42 percent) and left (68 percent) ejection fractions at rest. Bronchoscopic examination failed to show any endobronchial abnormality.

Pulmonary function tests revealed a moderately severe restrictive ventilatory defect, without a bronchodilator response (Figure 6). An exercise study showed normal resting minute ventilation with a normal ventilatory response to progressive workloads. There was exercise-induced arterial desaturation (Figures 7 and 8). No apparent anaerobic threshold was achieved with a heart rate (HR) max, suggesting a hemodynamic limitation to exercise, perhaps secondary to the development of pulmonary hypertension (Figure 9).

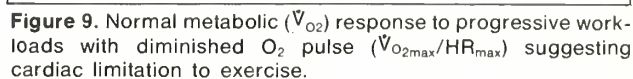
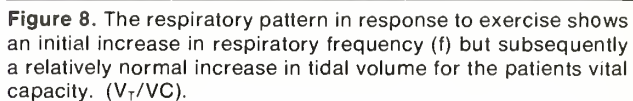
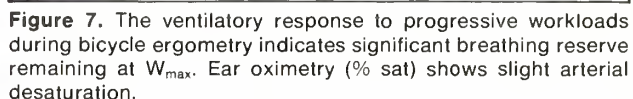
DISCUSSION

The true incidence of this entity is not known, since patients usually are asymptomatic and many

UNIVERSITY OF MARYLAND



The pathogenesis of this syndrome similarly is not known. One hypothesis suggests primary hypoplasia of the ipsilateral pulmonary artery with development of bronchiectasis as a result of superimposed infection. Another hypothesis supposes the primary abnormality to be an acquired obstructive process in the small peripheral bronchi from a single severe episode or repeated respiratory infections in childhood, causing bronchiolar-capillary destruction. The affected lung examined after resection shows obliterative disease of both proximal and peripheral



airways with alveolar septal destruction and emphysematous distention. Thus, it has been suggested that the findings are the result of inflammatory damage to airways and parenchyma in childhood, resulting in cessation of further development of lung and vasculature.

The microscopic findings can result from a variety of causes, including hydrocarbon ingestion, radiation therapy, measles, pertussis, and adenovirus infection in childhood.¹⁴ Radiographic findings are the mainstay for diagnosis of this syndrome. These include abnormal translucency of one lobe or lung, small hilar shadows, decreased vascular markings on the affected side and small or normal size of the affected portion of the lung. Fluoroscopy may reveal a shift of the mediastinum toward the affected side on inspiration and away from it on expiration, and limitation of the excursion of the ipsilateral hemidiaphragm and rib cage, reflecting the constant volume (diminished air entry) of the involved lung. These findings also can be seen in bullous disease due to a check-valve mechanism in the connecting bronchus. Nuclear ventilation-perfusion (V/Q) imaging shows markedly decreased perfusion of the affected lung associated with decreased ventilation and delayed washout.¹⁵ The V/Q study, along with spirogram, lung volume, and diffusion studies, can provide strong supportive evidence and exclude pulmonary embolism and congenital pulmonary artery agenesis. Bronchography reveals a typical pruned appearance as a result of abrupt termination of contrast medium at the end of small bronchi usually of the fourth and fifth generation. Proximal bronchi may appear normal. Bronchoscopy is indicated to exclude persistent obstruction to the

major bronchi by an endobronchial lesion, neoplastic or aspirated. Severe airway obstruction is seen in the affected lung, but also may be present in the contralateral lung. There is some evidence of defective hemodynamics and gas transfer in all patients, who have dyspnea with slight arterial hypoxemia, especially with exercise. Hypercapnia is not a feature.¹⁶ Many conditions radiographically resemble the Swyer-James-Macleod syndrome and must be excluded:

1. Asymmetry of chest wall due either to mastectomy or to absence or atrophy of the pectoralis major muscle or shoulder girdle.
2. Compensatory or obstructive emphysema.
3. Agenesis or hypoplasia of a lobe or lung.
4. Congenital pulmonary artery stenosis or hypoplasia.
5. Pulmonary embolism or unilateral pulmonary arterial occlusion.

SUMMARY

Unilateral hyperlucent lung should be considered an acquired inflammatory condition with resultant bronchiolar-capillary damage. The development of a proximal and peripheral obstructive process with resultant emphysema and bronchiectasis leads to cessation of development of the pulmonary arterial circulation. This entity should be differentiated from other causes of hyperlucent lung. Its characteristic features include abnormal unilateral translucency of an entire lung or lobe; normal or small size of affected lung; small hilar shadow; maintenance of constant volume of the affected lung during respiration; unusual bronchiectatic pattern; and suggestive nuclear V/Q scan and pulmonary angiogram. ■

REFERENCES

1. Swyer PR, James GCW: A case of unilateral pulmonary emphysema. *Thorax* 8:133-136, 1953.
2. Dornhorst AC, Heaf PJ, Semple SJG: Unilateral emphysema. *Lancet* 2:873-875, 1957.
3. Fouché RF, Spears JR, Ogilvie C: Unilateral emphysema. *Br Med J* 1:1312-1315, 1960.
4. Macleod WM: Abnormal transradiancy of one lung. *Thorax* 9:147-153, 1954.
5. Rakower J, Simon G: Unilateral hyperlucent lung (Swyer-James syndrome). *Am J Med* 33:864-872, 1962.
6. Nairn JR, Prime FJ: A physiological study of Macleod's syndrome. *Thorax* 22:148-155, 1967.
7. O'Dell CW Jr, Taylor A, Higgins CB, Ashburn WL, Schillaci RF, Alazraki NP: Ventilation-perfusion lung images in the Swyer-James syndrome. *Radiology* 121:423-426, 1976.
8. Gottlieb LS, Turner AF: Swyer-James (Macleod's) syndrome—variations in pulmonary-bronchial arterial blood flow. *Chest* 69:62-66, 1976.
9. Houk VN, Kent DC, Fosburg RG: Unilateral hyperlucent lung. A study in pathophysiology and etiology. *Am J Med Sci* 253:406-416, 1967.
10. Llamas R, Schwartz A, Gupta SK, Baum GL: Unilateral hyperlucent lung and polycythemia and cor pulmonale. *Chest* 59:690-692, 1971.
11. Margolin HN, Rosenberg LS, Felson B, Baum G: Idiopathic unilateral hyperlucent lung. A roentgenologic syndrome. *Am J Roentgenol* 82:63-75, 1959.
12. Reid L, Simon G: Unilateral lung transradiancy. *Thorax* 17:230-239, 1962.
13. Prowse OM, Fuchs JE, Kaufman SA, Gaensler EA: Chronic obstructive pseudoemphysema, a rare cause of unilateral hyperlucent lung. *N Engl J Med* 271:127-132; 1964.
14. Gold RW, Wilts JC, Adhikari TK, et al.: Adenoviral pneumonia and its complications in infancy and childhood. *J Can Assoc Radiol* 20:218-224, 1969.
15. White RI, James AE Jr, Wagner HN Jr: The significance of unilateral absence of pulmonary artery perfusion by lung scanning. *Am J Roentgenol* 111:501-509, 1971.
16. Warrell D, Hughes JMB, Rosenzweig DY: Cardiopulmonary performance at rest and during exercise in seven patients with increased transradiancy of one lung (Macleod's syndrome). *Thorax* 25:587-597, 1970.

NOTEBOOK

TRUSTEES' REPORT

A regular meeting of the Board of Trustees was held on Wednesday, April 26, 1989, at the Sheraton Meadowlands Hotel, East Rutherford. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Report of Executive Director . . .

(1) **Medicare** . . . Noted that significant headway has been made in the conversion process to Pennsylvania Blue Shield; specific problems addressed included: maximum allowable average charge; global billing; peritoneal dialysis services; Mohs chemosurgery; electromyography and nerve conduction studies; radiology problems from the imposed payment limitation for various radiological services furnished in a hospital setting; assistant at surgery; and referral of specific problems.

(2) **Advisory Council on Solid Waste Management** . . . Noted that Stanley R. Lane, MD, was appointed to the Advisory Council on Solid Waste Management.

(3) **S-2936** . . . Noted that with the bill's chances for passage looking good, medicine very likely will gain an effective licensing and disciplinary law assuring physicians due process and fair treatment.

(4) **NJHA and MSNJ versus the Ombudsman** . . . Noted that the litigation has been settled; the ombudsman rescinded the letter and resigned, and he was replaced by William Abrams.

(5) **Special Assessment** . . . Noted that two billings issued during 1988 made it clear that physi-

cians who chose not to pay the \$100 assessment would not be listed in the *Membership Directory*; a supplement to the *Membership Directory* will be issued.

(6) **Physicians' Health Program** . . . Noted that MSNJ received a subpoena from a plaintiff's attorney in a malpractice action, but MSNJ has refused to honor the subpoena.

(7) **1989 Dues** . . . Noted that as of April 30, 1989, there were 6,937 dues-paying members.

(8) **MSNJ Financial Statements** . . . Approved the financial statements for the period ending March 31, 1989.

(9) **New Jersey Cancer Registry** . . . Directed a letter advocating renewal of the contract for the New Jersey Cancer Registry be sent to the National Cancer Institute.

(10) **Physical Therapists** . . . Noted that the Board of Physical Therapy has received permission to appeal to the Supreme Court concerning a set of regulations.

Council on Legislation . . . Approved the following:

That the Board of Trustees approve the positions recommended by the Council on Legislature.

Also, extended thanks to Irving P. Ratner, MD, chairman of the Council, for the untiring efforts and extraordinary accomplishments of the Council on Legislation.

Unfinished Business . . .

AMA Delegation Attendance at Board Meetings . . . Accepted the following paragraph for inclusion in the AMA Delegation Handbook:

All current and newly elected delegates and alternates are expected to attend all Board meetings, be conversant with the agenda, and aware of all Board actions and Society policy. □

TRUSTEES' REPORT

A reorganization meeting of the Board of Trustees of the Medical Society of New Jersey was held on Sunday, April 30, 1989, at the Sheraton Meadowlands Hotel, East Rutherford. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Referrals from 1989 House of Delegates . . .

(1) **Substitute Resolution #9—Sexual Exploitation** . . . Approved referral of the following to the AMA delegation for preparation of an appropriate resolution to be introduced to the AMA House of Delegates:

Resolved, that MSNJ reaffirm that sexual exploitation in teaching and other professional relationships is unethical and unprofessional and at the appropriate time petition the AMA to so reaffirm.

(2) **Substitute Resolution #10—Mandatory Medicare Assignment as a Requirement of Licensure** . . . Referred the following to the AMA delegation for preparation of an appropriate resolution to be introduced to the AMA House of Delegates:

Resolved, that MSNJ continue its unalterable opposition to mandatory acceptance of Medicare assignment by physicians; and be it further

Resolved, that the AMA delegation re-

quest the AMA to petition the federal government to mandate that no state be allowed to legislate that physicians' acceptance of Medicare assignment be a requirement for medical licensure.

(3) Substitute Resolution for Resolutions #19 and #28—MSNJ Position on Abortion . . . Noted that no action on the following was required:

Resolved, that MSNJ, while recognizing that there are profound moral considerations involved in abortion, does not oppose a woman's right to have an abortion performed, provided it is done by a physician in a timely and safe manner, under guidelines previously set by the State Board of Medical Examiners.

(4) Resolution #31—Collective Bargaining . . . Referred the following first resolved to legal counsel to draft appropriate legislation and referred the following second resolved to the AMA delegation for preparation of a suitable resolution to be introduced to the AMA House of Delegates:

Resolved, that MSNJ draft and seek the introduction and passage of legislation that will enable private practitioners to collectively bargain under state law; and be it further

Resolved, that MSNJ request the AMA to seek the necessary amendments to federal law to permit private practitioners to engage in collective bargaining.

(5) Substitute Resolution #8—Nonpayment of Mandatory Assessment for Patient Education . . . Noted that the following was referred to *NEW JERSEY MEDICINE* with the understanding that implementation will be withheld until notification is received from the executive staff to proceed with the publication of the names of physicians who have not paid the special assessment:

Resolved, that the names of all those physicians who have not paid the special assessment be published in *NEW JERSEY MEDICINE*.

(6) Resolution #4—Tanning Salon Legislation . . . Directed the Secretary to send letters to the agencies named, as well as other appropriate agencies, requesting their participation in meeting with representatives of the Council on Legislation and the Council on Public Health regarding tanning salons, as described in the following:

Resolved, that MSNJ work with the New Jersey Department of Health, the Dermatological Society of New Jersey, and other appropriate agencies to determine what safety precautions are needed regarding tanning salons in New Jersey, and whether or not legislation similar to California law is advisable.

(7) Resolution #5—Change Polluting Habits . . . Approved referral of Resolution #5 to the Council on Public Relations for implementation:

Resolved, that MSNJ sponsor television public service announcements, and small spots on radio and television, and news releases to educate the public on proper waste disposal habits.

(8) Resolution #15—Medical Waste Disposal . . . Referred the following to the Committee on Membership Services for study and report:

Resolved, that MSNJ investigate and, if deemed possible by the Board of Trustees, endorse a medical waste disposal company and endeavor to obtain their services at a discount to its membership.

(9) Substitute Resolution #20—Mobile Intensive Care Unit (MICU) Squads . . . Referred the following and comments of Doctor Ratner to the Committee on Emergency Services for study and report:

Resolved, that MSNJ Board of Trustees direct the Committee on Emergency Medical Care to investigate the current effectiveness and relationship among attending physicians,

hospitals, and all emergency caregivers in the field, and to make recommendations through the Board of Trustees to appropriate state agencies concerning their findings.

(10) Resolution #1—PRO Denial . . . Approved referral of Resolution #1 to the Committee on Utilization Review Systems for implementation, and to the AMA delegation for preparation of an appropriate resolution to be introduced to the AMA House of Delegates:

Resolved, that MSNJ petition the Health Care Financing Administration to stop denials in instances where continued stay for admissions is based appropriately on social need; and be it further

Resolved, that cases of appropriate social necessity be reimbursable; and be it further

Resolved, that MSNJ instruct its delegates to the AMA to introduce a similar resolution at the next annual meeting of the AMA for implementation at the national level; and be it further

Resolved, that a copy of this Resolution be forwarded to the New Jersey Hospital Association for its information.

(11) Resolution #3—PRO/New Jersey Task Force . . . Referred Resolution #3 to the Committee on Utilization Review Systems for study and report:

Resolved, that MSNJ establish a "PRO New Jersey Task Force," similar to the one established by the Washington State Medical Association, in order to see that MSNJ members receive due process and fair treatment in PRO sanction hearings.

(12) Resolution #6—No Compromise on Malpractice Surcharge . . . Noted that this Resolution will remain with the Board of Trustees for ongoing consideration and action, dependent on the advice of legal counsel:

Resolved, that MSNJ immediately inform the Commissioner of Insurance

that it is uncompromising in its firm stand that a malpractice surcharge of any amount to physicians is unconscionable; and be it further

Resolved, that not only may there be no compromise but MSNJ will not accept any surcharge imposed on physicians that, if necessary, will go to court to prevent the New Jersey Department of Insurance from levying this surcharge.

(13) Resolution #7—No Malpractice Surcharge for any Physician in New Jersey . . . Noted that no action was required on Resolution #7 at this time but it will remain with the Board for consideration:

Resolved, that MSNJ represent all member physicians and fight to prevent any surcharge on any physicians in this state; and be it further

Resolved, that MSNJ inform its membership of this change.

(14) Resolution #26—Medicare Arbitrary and Capricious Denials . . . Noted that this Resolution will remain with the Board for ongoing consideration, with the understanding that frequent status reports will be provided by Mr. Maressa:

Resolved, that MSNJ continue to give the highest priority to effecting the means of correcting carrier abuses, such as lack of payment and other arbitrary and capricious denials of necessary medical services; and be it further

Resolved, that if the efforts of MSNJ are not successful, a special session of the House of Delegates should be called in the fall of 1989 to determine further actions.

(15) Resolution #16—Clear, Concise, and Complete Explanation of Benefits By All Third-Party Payors . . . Referred Resolution #16 to legal counsel to draft appropriate legislation:

Resolved, that MSNJ seek legislation which requires all third-party payors to explain to their beneficiaries, in clear and simple terms, those medical

services and procedures which they (third-party payors) will and will not cover; and be it further

Resolved, that MSNJ seek legislation that requires all third-party payors to provide an easily understandable indemnity payment schedule to their beneficiaries; and be it further

Resolved, that MSNJ vigorously resists any attempt to directly, indirectly, or surreptitiously shift the responsibility for explanation of policy benefits to physicians.

(16) Resolution #17 . . . Inadvisability of Medicare "Participation" . . . Approved referral of Resolution #17 to the AMA delegation for preparation of an appropriate resolution to be introduced to the AMA House of Delegates:

Resolved, that MSNJ urge the AMA to declare that Medicare "participation" status neither is in the best interest of its members, nor that of their patients; and be it further

Resolved, that MSNJ urge the AMA to oppose discriminatory policies regarding Medicare "nonparticipants" being used for the federal government; and be it further

Resolved, that copies of Resolution #17 be distributed to all state medical societies for their information.

(17) Resolution #23—Assisting Surgeons and Medicare Reimbursement . . . Approved referral of Resolution #23 to legal counsel for consideration and report:

Resolved, that MSNJ continue to vigorously protest the failure of Pennsylvania Blue Shield to pay for a surgical assistant for all procedures which involve entry into the major body cavities and demand Medicare reimbursement for assistants in such procedures since current state law requires the presence and participation of an assisting surgeon in those instances.

(18) Resolution #24—Physician Attestation for Medicare Reimbursement . . . Referred Resolu-

tion #24 to legal counsel for study and report:

Resolved, that MSNJ take appropriate action to assure that the hospital not only be responsible for proper coding, but also bear any liability for fines or penalties under federal law for both incorrect coding and improper coding which go beyond the information attested to by the physician.

(19) Substitute Resolution #27—Medicare Reimbursement . . . Referred the following to legal counsel for consideration and report:

Resolved, that, if a physician requests review by a peer of his or her specialty of a complaint, problem, or issue, Pennsylvania Blue Shield should insure that such a practicing specialist (board certified or equal qualification) has reviewed the issue and further, that the requesting physician be assured, in writing, that this review has occurred.

(20) Resolution #29—Assignment of Laboratory Tests . . . Directed the secretary to send an appropriate letter to United States Congressmen; also, approved referral of the Resolution to the AMA delegation for development of a suitable resolution for introduction to the AMA House of Delegates:

Resolved, that MSNJ inform the United States Congress of the inconvenience and medical risk forced on patients by current laws with regard to office laboratory testing; and be it further

Resolved, that MSNJ urge Congress to permit patients to be reimbursed for, and physicians to perform, tests in their offices on an unassigned basis.

(21) Resolution #33E—Removal of Discriminatory and/or Biased Provisions Toward Nonparticipating Physicians . . . Referred Resolution #33E to the AMA delegation for preparation of an appropriate resolution to be introduced to the AMA House of Delegates:

Resolved, that MSNJ request the

AMA to immediately and vigorously petition Congress, HCFA, and Part B carriers, with regard to Medicare, to remove discriminatory and/or biased provisions toward nonparticipating physicians; and be it further

Resolved, that MSNJ ask the AMA to immediately and vigorously petition Congress, HCFA, and the Part B carriers to ensure that explanation of Medicare benefits states nothing more than the reimbursement for medical services and procedures.

(22) Resolution #35E—Negotiating with Medicare . . . Noted that this Resolution will be maintained within the Board of Trustees:

Resolved, that the New Jersey delegation to the AMA request the AMA to lobby Congress to set up an arbitration mechanism between the Health Care Financing Administration and the AMA.

(23) Resolution #36E—ICD-9-CM Coding Regulations . . . Referral of Resolution #36E to the AMA delegation for preparation of an appropriate resolution to be introduced to the AMA House of Delegates:

Resolved, that MSNJ strongly request that the Health Care Financing Administration rescind implementation of the ICD-9-CM coding regulations.

(24) Resolution #14—Manpower Organization for Political Action . . . Approved referral of this Resolution to a committee to be composed of the members of the Executive Committee and several other members, to be selected by the president, for consideration and report back to the Board:

Resolved, that MSNJ set up an infrastructure to:

- (1) Collect and collate demographic data of physicians, their spouses, children of voting age, and employees.
- (2) Maintain a constant flow of legislative information to these groups to heighten their awareness of pertinent matters.

- (3) Organize a chain of communication to ensure a comprehensive response from the targeted group thereby effectively amplifying the influence of the group as a whole.

Unfinished Business . . . Noted that the resolution on surgical assistants was rejected by the House of Delegates. □

UMDNJ NOTES

UMDNJ conferred professional degrees and certificates on more than 700 students on May 24, 1989, at the 16th annual commencement at the Garden State Arts Center, Holmdel. UMDNJ awarded 294 Doctor of Medicine (MD) degrees, 75 Doctor of Dental Medicine (DMD) degrees, 52 Doctor of Osteopathy (DO) degrees, 11 Doctor of Philosophy (PhD) degrees, 6 Master of Science (MS) degrees, and 176 certificates in a variety of health-related professional programs. For the first time, one student received an MD and PhD degree simultaneously. Eight post-doctoral certificates were awarded in several dental specialties. In addition, two students earned the first Bachelor of Science (BS) degrees to be awarded by the University. (The degrees, in clinical laboratory sciences, were conferred in conjunction with Rutgers University.) Joint degrees with Rutgers and the UMDNJ-Graduate School of Biomedical Sciences included 40 MS degrees and 37 PhD degrees. Master of Public Health (MPH) degrees were awarded to 28 jointly by UMDNJ-Robert Wood Johnson Medical School and Rutgers University.

Hospital care for black and Hispanic children will suffer if the current hospital payment system is not increased to reflect the rising cost of treating these patients. Dr. Eric Munoz, medical director of UMDNJ-University Hospital, Newark, made this assertion in a report that found minority pediatric patients: stay in hospitals

longer than other patients; have a higher rate of expensive emergency admissions; endure greater severity of illness; and incur higher diagnostic costs.

"Therefore, total hospital cost per minority pediatric patient is higher than it is for white patients," Dr. Munoz said. "We face an important equity issue as we struggle to provide comprehensive cost-effective services to all at an acceptable cost to society. If the current DRG payment system is not increased, we will have a growing population of children who are denied services."

Surgeons at UMDNJ's Newark campus performed the first brain surgery in New Jersey to treat epilepsy. The patient, Ken Boger, a 42-year-old Vietnam veteran from Westfield, who has had seizures since age 15, underwent the surgery, a temporal lobectomy, on April 12 and was present at a news conference May 2 at UMDNJ-University Hospital.

The lead surgeon, Dr. Abbott J. Krieger, chief of neurosurgery, said that during the five-hour procedure, a piece of the skull was temporarily removed, the lining over the brain was opened, and the brain was monitored for seizures. After mapping the area of activity, surgeons removed part of the temporal lobe. Improved testing techniques, including the use of computerized axial tomography (CAT scan) and magnetic resonance imaging (MRI), now make it possible to get an exquisite location of the lesion," explained Dr. Orrin Devinsky, director of the hospital's Comprehensive Epilepsy Center. Drs. Krieger and Devinsky said there was a 70 to 90 percent chance for a "dramatic reduction" in the frequency of seizures experienced by Mr. Boger.

In response to an increasing incidence of Lyme disease, a new health group to combat the ailment has been formed by UMDNJ and Jersey Shore Medical Center,

Neptune. With the number of cases this year reported to be up to 1,400, Lyme disease now is considered a significant health concern in New Jersey. The new unit, the New Jersey Lyme Disease Collaborative Studies Group, will educate health professionals and the public about the symptoms and hazards of lyme disease in New Jersey.

The collaboration combines the expertise of the Lyme Disease Resource Center at Jersey Shore Medical Center and the Lyme Disease Center at UMDNJ-Robert Wood Johnson Medical School, New Brunswick. Lyme disease, caused by the bite of a deer tick, frequently is misdiagnosed and underreported. Its symptoms usually are very nonspecific and can be confusing, leading to delayed treatment. Serious complications can include neurological, heart, eye, and joint problems. □ Stanley J. Bergen, Jr, MD

MSNJ AUXILIARY

Mrs. Sevim Omay is the 1989-1990 president of the Medical Society of New Jersey Auxiliary. At the annual session of the Medical Society of New Jersey Auxiliary, Mrs. Omay was installed as the 63rd president; she is the 5th Auxiliary member from the Passaic County Auxiliary to hold that honor.

Mrs. Omay was born and raised in Turkey, and she graduated from Turkey's Fashion Institute. Sevim married Yurt Omay, an obstetrician-gynecologist, and in 1957, the couple emigrated to the United States.

Yurt and Sevim have raised two children. Their son, Cem, is following in his father's footsteps in obstetrics and gynecology and their daughter, Meltem, is a graduate of Rutgers University with a degree in psychology.

Although Sevim currently is busy with her successful business

in the fashion industry, she works tirelessly for her hospital, state, and county auxiliaries. Mrs. Omay has worked on the Guild of St. Mary's Hospital, Passaic, chaired a variety of its functions, and served as its president.

Passaic County Medical Society Auxiliary and the Medical Society of New Jersey Auxiliary have been an inspiration to Sevim. She works very closely with Passaic County Medical Society, stopping in at their office every chance she can.

Among the various organizations Sevim has served include: South Bergen Hospital Guild, Deborah Heart and Lung Center, German-American Soccer League, Wallington High School Music-Parent Association, and the Lion's Club. In all of her activities, she has been supported greatly by her family. Sevim enjoys gardening, gourmet cooking, and museum going. However, everything gets put on hold when a Giants' game is on.

Sevim has been an Auxiliary member for ten years, three in Bergen County, and seven in Passaic County. She has endeared herself to Auxiliary members across the state by her example of hard work and commitment—to the Auxiliary and to the medical profession. Sevim's only regret is that she did not learn about the Medical Society of New Jersey Auxiliary many years ago. □

PLACEMENT FILE

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY

- B.E. Shapiro, MD, 4144 Buttercup Ln., Plymouth Meeting, PA 19462.

Temple 1985. Board eligible. Available.

- Kishorkumar S. Vekaria, MD, 4805 Oxen Ct., Tampa, FL 33624. Baroda (India) 1982 and South Florida 1989. Board eligible. Available.
- Ricky Zegelstein, MD, 4600 Ninth Ave., Brooklyn, NY 11220. Sackler 1984. Board eligible. Group or partnership. Available.

FAMILY PRACTICE

- Leonid Belopolsky, MD, 955 Chanticleer Dr., Cherry Hill, NJ 08003. Moscow 1961. Board certified (ANES). Also, internal medicine. Available.

INTERNAL MEDICINE

- Michael G. Donnelly, MD, 10 Overlook Rd., Apt. 4H, Summit, NJ 07901. Medical College of Pennsylvania 1987. Board eligible. Group or partnership. Available.
- Prakash J. Doshi, MD, 5676 Broadview Rd., #507, Parma, OH 44136. Bombay (India) 1984. Board eligible. Solo, partnership, group. Available.
- Lalitha B. Iyer, MD, 35 Winthrop Rd., Edison, NJ 08817. Madras (India) 1980. Board eligible. Group, partnership, emergency room. Available.
- Charles Neal Jeck, DO, 9273-A Jamison Ave., Philadelphia, PA 19115. Philadelphia Osteopathic 1985. Board eligible. Group. Available.
- Leonid Belopolsky, MD, 955 Chanticleer Dr., Cherry Hill, NJ 08003. Moscow 1961. Board certified (ANES). Also, family medicine. Available.

ORTHOPEDICS

- D.C. Brown, MD, 2319 Sayre Dr., Princeton, NJ 08540. Available.

PEDIATRICS

- Niranjana S. Patel, MD, 2003 Valley View Dr., Pineville, LA 71360. B.J. Medical College (India) 1982. Board eligible. Also, emergency medicine. Group, hospital-based, partnership. Available.

SURGERY

- Robert A. Aldoroty, PhD, MD, 1270 Fifth Ave., New York, NY 10029-3417. Columbia 1984. Board eligible. Group or partnership. Available. □

CE
Pages 566-568

John P. Caufield Technology Extension Center

presents

First Symposium on Transfer of Cancer Technology

SEPTEMBER 14-16, 1989

at

Princeton Marriott Hotel

For additional information contact:

Kim Mazzei

201-456-7051

AMA Class 1 credits (21 credit hours) can be provided for attendees who request them.

ANNUAL CME ASSEMBLY

presented by the

**MEDICAL SOCIETY OF THE
STATE OF NEW YORK**

**CASE MANAGEMENT AND
CLINICAL CARE DILEMMAS**

SEPTEMBER 15-16, 1989

THE NEW YORK HILTON, NEW YORK CITY

HIGHLIGHTS . . .

24 CME Sessions: Panel Discussions; Technical Exhibits, Hospitality Breaks include Coffee Service, Cocktail/Reception, (Friday), Continental Breakfast, Buffet Luncheon, (Saturday).

Registration: A \$25 fee for members of the New Jersey State Medical Society; no fee for residents, medical students, or medical assistants. Non-member physicians—\$50; Allied Professions \$10. We are accredited by the Accreditation Council for CME.

For a copy of the preliminary program contact:
MSSNY, Dept. of Meetings Management
420 Lakeville Road,
P.O. Box 5404, Lake Success, N.Y. 11042.
(516) 488-6100

CONTINUING EDUCATION

MEDICINE

September

- 15 **What the Primary Physician Must Know and Do To Save Diabetic Legs**
11 A.M.-12 Noon.—St. Clare's Riverside Medical Center, Denville
(AMNJ and NJDOH)

OCCUPATIONAL MEDICINE

August

- 16 **Lead Poisoning**
9-10 A.M.—Warren Hospital, Phillipsburg
(AMNJ and NJDOH)

September

- 6 **Lead Poisoning**
12 Noon-1 P.M.—St. James Hospital, Newark
(AMNJ and NJDOH)
- 7 **Lead Poisoning**
11:45 A.M.-1 P.M.—John F. Kennedy Medical Center, Edison
(AMNJ and NJDOH)
- 11 **Occupational Asthma—Strategies for Treatment and Prevention in New Jersey**
12 Noon-1 P.M.—Warren Hospital, Phillipsburg
(AMNJ and NJDOH)
- 13 **Occupational Asthma**
11:30 A.M.-12:30 P.M.—Rahway Hospital, Rahway
(AMNJ and NJDOH)
- 20 **Lead Poisoning**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic
(AMNJ and NJDOH)
- 20 **Occupational Asthma**
12 Noon-1 P.M.—St. James Hospital, Newark
(AMNJ and NJDOH)
- 21 **Lead Poisoning**
11:30 A.M.-12:30 P.M.—Columbus Hospital, Newark
(AMNJ and NJDOH)
- 21 **Occupational Asthma**
11:45 A.M.-1 P.M.—John F. Kennedy Medical Center, Edison
(AMNJ and NJDOH)

- 22 **Occupational Asthma—Strategies for Treatment and Prevention in New Jersey**
8:30-9:30 A.M.—United Hospitals Medical Center, Newark
(AMNJ and NJDOH)
- 22 **Lead Poisoning**
11:30 A.M.-12:30 P.M.—Overlook Hospital, Summit
(AMNJ and NJDOH)
- 25 **Lead Poisoning**
11:30 A.M.-12:30 P.M.—East Orange General Hospital, East Orange
(AMNJ and NJDOH)
- 27 **Occupational Asthma—Strategies for Treatment and Prevention in New Jersey**
10:30-11:30 A.M.—Saint Mary's Hospital, Passaic
(AMNJ and NJDOH)

ORTHOPEDICS

August

- 10 **Nonoperative Management of Chronic Back Pain**
2-3 P.M.—John E. Runnells Hospital, Berkeley Heights
(AMNJ)
- 10 **Osteomyelitis**
12 Noon-1 P.M.—Community Medical Center, Toms River
(AMNJ)

PSYCHIATRY

August

- 3 **Topographic Brain Mapping and Electrodiagnosis**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)
- 10 **CT Scan Studies in Teenagers with Schizophrenia**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)
- 15 **Issues in the Treatment of Anxiety: Drug Dependence and Abuse**
7:30-8:30 A.M.—Mercer Medical Center, Trenton
(AMNJ and Mercer Medical Center)

- 17 **Adolescent Health Issues**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

- 31 **The Neuropsychiatric Aspects of AIDS**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

September

- 7 **Parkinson's Disease**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)
- 14 **Psychopathology as Predictor of Treatment Outcome in Alcoholics**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)
- 20 **Loneliness: The Pain and the Prevalence**
All day—Carrier Foundation, Belle Mead
(Carrier Foundation)
- 21 **Employee Assistance Programs**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

SURGERY AND ITS SPECIALTIES

September

- 11 **Surgical Procedures for Chronic Pancreatitis**
12 Noon-1 P.M.—Hospital Center at Orange, Orange
(AMNJ)
- 14- **Interventional Vascular**
- 17 **Surgery/Therapy**
6:45 P.M.—Sheraton Meadowlands Hilton, East Rutherford
(AMNJ)

UROLOGY

August

- 24 **Clinical Cases Presentation**
6:30-7 P.M.—Robert Wood Johnson Medical School, New Brunswick
(UMDNJ)

BOARD REVIEW COURSE IN CARDIOVASCULAR DISEASE

Presented by

PHILADELPHIA HEART INSTITUTE

Presbyterian Medical Center

and

THE GRADUATE HOSPITAL

Co-sponsored by the Council

on Clinical Cardiology of the



American Heart Association

September 26-29, 1989

**Wyndham Franklin Plaza
Philadelphia, Pennsylvania**

Program Committee

Bruce C. Berger, M.D., Michael S. Feldman, M.D.,
Leonard N. Horowitz, M.D., Ami S. Iskandrian, M.D., Thomas H. Kreulen, M.D.
Joel Morganroth, M.D., Bernard L. Segal, M.D.

This program is designed to provide the physician with an intensive survey of our current understanding of the clinical manifestations, pathophysiology and treatment of cardiovascular disease. The course will also prepare the physician for the Board Examination in Cardiovascular Disease.

For registration information contact:

Ms. Karen Pushkar
Philadelphia Heart Institute
Presbyterian Medical Center
39th & Market Streets, Philadelphia, PA 19104
(215) 662-9222

The Accreditation Council for Continuing Medical Education recognizes the American Heart Association as an accredited sponsor for continuing medical education activities for physicians. The American Heart Association designates this continuing medical education activity for 44 credit hours in Category I of the Physician's Recognition Award of the American Medical Association.

IN MEMORIAM

Elmer Alpert. A leader in medical research at Merck and Co., Inc., Elmer Alpert, MD, died on January 7, 1989, at the age of 76. A New Haven, Connecticut native, Dr. Alpert was graduated from New York University College of Medicine, where he received his medical degree. During his 23 years at Merck and Co., Inc., Dr. Alpert played a significant role in the management of clinical programs on investigational drugs such as steroid hormones and antibiotics, and served as director of clinical research and executive director of medical administration. In addition, Dr. Alpert was an internal medicine practitioner in New York, and a physician in the nutrition clinic of the New York Department of Health. A diplomate of the American Board of Nutrition, Dr. Alpert was director of the Laurentian Hormone Conference for 5 years, and was secretary of the Committee on Nutrition of Industrial Workers of the National Research Council. He was a member of the AMA, of the Endocrine Society, of the American Rheumatism Society, and of our Mercer County component.

Albert W. Cloud. Retired surgeon, Albert William Cloud, MD, died on July 22, 1988, in Englewood. Born in 1900, Dr. Cloud received his medical degree from Harvard in 1925. He was chief of surgery and chief of medical services. Dr. Cloud was a member of our Bergen County component and of the American Medical Association. He was a fellow of the American College of Surgeons.

William H. Errgong. Retired since 1986 from 33 years of private ophthalmology practice in New Brunswick, William Henry Errgong, MD, died on February 8, 1989, at the age of 73. A staff member since 1953 of Robert Wood Johnson University Hospital, and St. Peter's Medical Center, New Brunswick, where he served as chief of ophthalmology, Dr. Errgong worked for the Public Health Service from 1941 to 1953, attaining the rank of lieutenant commander. A diplomate in ophthalmology and a fellow of the American College of Surgeons, Dr. Errgong was a member of the American Academy of Ophthalmology, of the AMA, and of our Middlesex County component.

Rev. James F. Flanagan. Ordained priest and retired obstetrician/gynecologist Rev. James Francis Flanagan, MD, died on February 16, 1989, at the age of 76. Born in Newark and a lifelong area resident, Dr. Flanagan received his medical degree from Jefferson Medical College of Philadelphia, Pennsylvania, in 1941. He maintained a general practice in Newark from 1948 to 1953, when he established a specialized obstetrics practice in East Orange. Dr. Flanagan also was clinical professor of obstetrics and gynecology at UMDNJ-New Jersey Medical School, and was affiliated with Saint James Hospital, Newark. A diplomate in obstetrics and gynecology and a fellow of the American College of Surgeons, Dr. Flanagan was a member of our Essex County component and of

the AMA. As lieutenant commander in the United States Navy during World War II, Dr. Flanagan served at medical facilities in Central and South America, and on a destroyer in the North Atlantic.

Philip V. Lynch. Retired pathologist Philip Vincent Lynch, MD, died on October 30, 1988. A 1916 Cork, Ireland native, Dr. Lynch earned his medical degree at Ireland University Medical College, in 1942. Licensed to practice medicine in Ireland, Dr. Lynch was a physician in Glasgow, Scotland; Weert, Holland; Chiswick, West London; and Dublin, Ireland, until emigrating to the United States. During World War II, he was a captain in the British Army. After obtaining a New Jersey medical license, Dr. Lynch became affiliated with our Lady of Lourdes Hospital, Camden, in addition to maintaining a private practice. Dr. Lynch was a member of our Camden County component and of the AMA.

David M. Mayer. The first plastic surgeon at Holy Name Hospital, Teaneck, David McCullagh Mayer, MD, died on January 29, 1989, at the age of 87. A native of Corning, New York, Dr. Mayer received his medical degree from New York Medical College in 1932. In addition to practicing plastic surgery in Rutherford and New York City, Dr. Mayer became affiliated with East Orange Veterans Administration Medical Center. Professor of clinical surgery at UMDNJ-New Jersey Medical School and a member of the AMA,

Dr. Mayer received the AMA's Physician Recognition Award. A diplomate in plastic surgery and a fellow of both the American and International Colleges of Surgeons, he was a member of the American Society of Plastic and Reconstructive Surgery, of the American Society of Maxillofacial Surgeons, of the Academy of Medicine of New Jersey, of the New Jersey Surgical Society, and of our Bergen County component. Serving during World War I and II, Dr. Mayer was a hospital administrator in Europe, and was awarded the rank of brigadier general in 1959.

George L. McCarthy. Retired family physician George Logan McCarthy, MD, died on January 25, 1989. He was graduated from Jefferson Medical College of Philadelphia, Pennsylvania, where he received his medical degree in 1928. Affiliated with Wayne General Hospital, Dr. McCarthy maintained a private practice. During World War II, Dr. McCarthy was a lieutenant commander in the United States Navy. He was a member of our Passaic County component and of the AMA. In 1978, Dr. McCarthy was a recipient of the MSNJ's Golden Merit Award, for holding his medical degree for 50 years.

Marion McIlveen. Retired Ridgewood pediatrician Marion McIlveen, MD, died on January 28, 1989, at the age of 77. Born in Jersey City, Dr. McIlveen was graduated from the Medical College of Pennsylvania, Philadelphia, in 1938. An instructor in pediatrics for Cornell Medical Center, New York, Dr. McIlveen was a practitioner in Ridgewood for 32 years before retirement. She was a member of our Bergen County component and of the AMA.

John J. Muccia. Chief of anesthesiology at Christ Hospital, Jersey City, for 40 years, retired physician John J. Muccia, MD, died

on January 9, 1989. A 1906 New York City native, Dr. Muccia was awarded a medical degree from Long Island College of Medicine, New York, in 1932. A diplomate in anesthesiology, Dr. Muccia was a fellow of the American College of Anesthesiologists and of the International College of Anesthetists, and was a member of our Hudson County component and of the AMA. Dr. Muccia trained military physicians during World War II while serving as a major in the U.S. Army medical corps. He was the first physician in Hudson County to be honored with the title of diplomate in anesthesiology. In 1982, he received the Golden Merit Award from MSNJ.

Harvey R. Nova. Former chairman of the Englewood Hospital Neurosurgery Department, Harvey Ronald Nova, MD, died on February 12, 1989. A 1935 New York City native, Dr. Nova earned his medical degree from Columbia University College of Physicians and Surgeons, New York, in 1960. In addition to running a private Bergen practice, Dr. Nova became affiliated with the Englewood Hospital Association and The Valley Hospital, Ridgewood, and was associate professor of clinical neurosurgery at Columbia University. From 1960 to 1962, Dr. Nova was a captain in the United States Army medical corps. A diplomate in neurological surgery, Dr. Nova was a member of the New Jersey Neurosurgical Society and of our Bergen County component.

Frederick K. Poller. Retired internal medicine specialist Frederick Kristian Poller, MD, died on November 21, 1988, at the age of 88. Born in Germany, Dr. Poller received his medical degree at the Faculty of Medicine of Albertus University, Konigsberg, Germany, in 1924. As well as operating a private practice in Irvington, Dr. Poller was affiliated with St.

Michael's Medical Center, Newark. Retired from active medical practice in 1974, Dr. Poller was member of the Academy of Medicine of New Jersey, of the Irvington Physician's Club, of our Essex County component, and of the American Medical Association.

Alfred W. Weigl. Retired since 1983 from internal medicine practice, Alfred William Weigl, MD, died on September 12, 1988. A 1911 native of Vienna, Austria, Dr. Weigl received his medical degree from the Medical Faculty, University of Zurich, Switzerland, in 1939. After emigrating to the United States, Dr. Weigl opened a private practice and became affiliated with several New York City hospitals, including Mount Sinai Medical Center and Jewish Memorial Hospital. He was a professor for New York Medical College and a member of the New York Medical Society, of the American College of Emergency Physicians, of the American Occupational Medical Association, of the American College of Physicians, of the Industrial Medicine Association, of the Royal Society of Health, London and of our Cumberland County component. For excellence in continuing education, Dr. Weigl was the recipient of two AMA recognition awards (1969 and 1972).

Jon M. Wilson. Retired for several years from gynecology practice, Jon Milton Wilson, MD, died on October 2, 1988. A 1922 New York City native, Dr. Wilson received his medical degree from New York Medical College in 1947. A fellow of the American College of Obstetricians and Gynecologists, Dr. Wilson was a member of our Somerset County component, of the AMA, and of the Association of Military Surgeons. He was affiliated with Somerset Medical Center, Somerville. From 1950 to 1952, he was major in the U.S. Army medical corps.

EDITORIAL CRITERIA

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. All material published is copyrighted by MSNJ.

Content. The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevant to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made to an audience in New Jersey.

Assignment of Copyright. In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statement accompany-

ing material offered to *NEW JERSEY MEDICINE* must contain the following language and must be signed by all authors.

"In consideration of *NEW JERSEY MEDICINE* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *NEW JERSEY MEDICINE*.

Specifications. Submit two manuscripts that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods should be identified.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 30-word abstract.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission must be submitted.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

References should not exceed 35 citations except in review articles, and should be cited consecutively by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in numerical order. The style of *NEW JERSEY MEDICINE* is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

Publication Policy. Receipt of each manuscript will be acknowledged; the paper will be referred to the Editorial Board. The final decision is reserved for the editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. Galley proofs will be submitted to the author for correction.

Reprint Orders. Reprints may be ordered after the author is notified that the article has been selected for a specific issue. A check for the cost of reprints must accompany that order.

Communications. All communications should be sent to the editor, *NEW JERSEY MEDICINE*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

1989 Annual Meeting

The 223rd Annual Meeting of the Medical Society of New Jersey was held at the Sheraton Meadowlands Hotel in East Rutherford from April 27, 1989, to April 30, 1989. Paul J. Hirsch, MD, was inaugurated as the 197th president of the Society.



Drs. Paul Hirsch and Palma Formica attend the dinner-dance honoring Dr. Hirsch as the 197th president of the Society.



The 1989-1990 MSNJ Board of Trustees (seated left to right): Gerald H. Rozan, MD; Bernard Robins, MD; William E. Ryan, MD; Douglas M. Costabile, MD; Paul J. Hirsch, MD; Joseph A. Riggs, MD; Palma E. Formica, MD; (standing left to right) Joseph P. Zawadsky; John J. Pastore, MD; Michael M. Heeg, MD; Edith A. Goldie; R. Gregory Sachs, MD; Herman M. Robinson, MD; Louis L. Keeler, MD; Carl Restivo, Jr, MD; Fred M. Palace, MD; Angelo S. Agro, MD; Joel S. Cherashore, MD; Edwin W. Messey, MD; Shah M. Chaudhry, MD; and Philip J. Jasper, MD.

1989 ANNUAL MEETING



Drs. Harry Carnes and Palma Formica relax at the JEMPAC wine and cheese reception.



Howard D. Slobodien, MD, editor-in-chief of *NEW JERSEY MEDICINE* (seated, second from right) and Dr. and Mrs. Ralph Fioretti (far right) and others enjoy the festivities at the Saturday night dinner-dance.



Golden Merit Award recipients accept their honors at the 33rd Annual Awards ceremony.



The MSNJ Auxiliary at the annual breakfast meeting with Auxiliary president Mrs. Sevim Omay (seated, far right).



The exhibitors hall included a booth prepared by the Medical Inter-Insurance Exchange of New Jersey, with hosts Sharon Simmons and William E. Reilly.

1989 TRANSACTIONS



Table of Contents

Reference Committee "A"

President/Chairman of the Board	3
Judicial Council	5
Supplemental Reports #1 and #2	6
AMA Delegation	7
Committee on Long-Range Planning and Development	10
Supplemental Report #1	11
Committee on Physicians' Health	12
Resolution #9: Sexual Misconduct	14
Resolution #10: Medicare Assignment—Resource-Based Relative Value Scales ..	15
Resolution #19: MSNJ Policy on Abortion	16
Resolution #28: MSNJ Position on Abortion	17
Resolution #31: Collective Bargaining	18
Members: Terry A. Johnston, MD, Chairman; Kishor J. Jobanputra, MD; Paula S. Krauser, MD; Frank L. Redo, MD; Robert I. Salasin, MD; Russ C. Camangian, MD, Alternate	

Reference Committee "B"

Secretary	19
Treasurer	21
Committee on Finance and Budget	23
Council on Mental Health	26
Council on Public Health	27
Committee on Annual Meeting	28
Nominations for Emeritus Membership	29
Supplemental Reports #1, #2, #3	30
Resolution #2: Summary of Convention Issues and Resolutions	32
Resolution #4: Tanning Salon Legislation	33
Resolution #5: Change Polluting Habits	33
Resolution #8: Nonpayment of Mandatory Assessment for Patient Education	34
Resolution #15: Medical Waste Disposal	35
Resolution #20: Mobile Intensive Care Unit (MICU) Squads	36
Members: Patricia G. Klein, MD, Chairman; Henriette E. Abel, MD; Michael H. Bernstein, MD; Michael P. Ciencewicki, Jr, MD; Martin L. Cohen, MD; Francis J. Lumia, MD, Alternate	

1988 Transactions

The House of Delegates approved the Transactions of the 1988 Annual Meeting, as published in *NEW JERSEY MEDICINE*.

Action To Limit Debate

The House of Delegates agreed, upon motion, that no one may speak more than once on any given subject except in rebuttal or by express permission of the House, and that floor time in each instance shall be limited to four minutes unless exception is made by the House.

Reports and Resolutions

Reports and resolutions and the actions, thereon, are included under the Reference Committee to which they were assigned. The House takes action only on the resolved sections of a resolution.

Reference Committee "C"

Council on Medical Services	37
Resolution #1: PRO Denial	38
Resolution #3: PRO/New Jersey Task Force	39
Resolution #6: No Compromise on Malpractice Surcharge	40
Resolution #7: No Malpractice Surcharge for Any Physician in New Jersey	40
Resolution #12: Unfair Medicare Reimbursement	41
Resolution #16: Clear, Concise, and Complete Explanation of Benefits By All Third-Party Payors	41
Resolution #17: Inadvisability of Medicare "Participation"	42
Resolution #18: Overutilization of Cardiac Pacemaker Testing	43
Resolution #23: Assisting Surgeons and Medicare Reimbursement	44
Resolution #24: Physician Attestation for Medicare Reimbursement	44
Resolution #25: Medicare Reimbursement and Preoperative Consultations	45
Resolution #26: Medicare—Arbitrary and Capricious Denials	45
Resolution #27: Medicare Reimbursement—Urology	46
Resolution #29: Assignment of Laboratory Tests	47
Resolution #30: Medicare Global Fees	48
Resolution #32: Medicare Global Fees	49
Resolution #33E: Removal of Discriminatory and/or Biased Provisions Toward Nonparticipating Physicians	49
Resolution #34E: MSNJ Peer Review Organization Foundation for Practicing Members	50
Resolution #35E: Negotiating with Medicare	51
Resolution #36E: ICD-9-CM Coding Regulations	51
Members: Robert J. Weierman, MD, Chairman; S. Manzoor Abidi, MD; George Leipsner, MD; Paul C. Royce, MD; John A. Sakson, III, MD; Bernard A. Pekala, MD, Alternate	

Reference Committee "D"

Council on Public Relations	52
Supplemental Report #1	54
Council on Legislation	56
Supplemental Reports #1 and #2	65
Resolution #13: Surgical Assistants	68
Resolution #14: Manpower Organization for Political Action	68
Resolution #21: New Jersey Ombudsman for the Institutionalized Elderly	69
Resolution #22: Registered Care Technologists	70
Members: Aiden J.M. Doyle, MD, Chairman; John F. Fisher, MD; Anthony R. Giorgio, MD; Glenn P. Jacobs, MD; Saul M. Tischler, MD; Giovanni Lima, MD, Alternate	

Reference Committee on Constitution and Bylaws

Committee on Revision of Constitution and Bylaws	71
Resolution #11: Eligibility for MSNJ Emeritus Membership	76
Members: Robert H. Stackpole, MD, Chairman; Donald J. Cinotti, MD; John S. Garra, MD; Glenn P. Lambert, MD; Alan Wasserstrum, MD; Mohan C. Makhija, MD, Alternate	

Additional Materials

Informational Report: Senior Citizens Task Force	77
Informational Report: Resolution on Surgical Assistants	78
Offices Filled by Election	79

President/Chairman of the Board

PALMA E. FORMICA, MD

(Reference Committee "A")

As the 222nd year of the Medical Society of New Jersey draws to a close, it is the time to give a summation of the stewardship of this administration.

This has not been a quiet, uneventful year. Shortly after taking office, I agreed to represent you in a suit against the commissioner of insurance, whenever he adopts his proposed surcharge to force all physicians to pay for the mismanagement of the Medical Malpractice Reinsurance Association. Your leadership heard your cry—"Not one cent for tribute." The Medical Society hired Judge Herbert Stern to prepare our attack to preserve our constitutional rights. Through the Legislature, we were able to force the commissioner to hold a public hearing; over 200 members attended the hearing. You were magnificent. Not one word was said in favor of the surcharge, but much was put into the record challenging its wisdom. The hearing officer's report vindicated our position, in part. She said it was not fair, but recommended we pay \$48 million through a 2.5 percent surcharge. A 2.5 percent surcharge still is 2.5 percent too much. At this writing, the battle continues.

The sensationalism created by last year's distorted SCI report has resulted in a strengthened and expanded Physicians' Health Committee. Legislation has been introduced with input from MSNJ to reform the way cases are handled by the State Board of Medical Examiners. It still is pending in committee.

Mandatory assignment legislation was defeated once again, thanks to all of you. We continue to care for the aged and the poor voluntarily.

The Senior Courtesy Program is progressing in each of the counties. On the local level—at the grassroots—this program will succeed. We salute the many physicians in their respective county organizations for their dedication and concern. We must continue to be vigilant and proactive. The war against mandatory assignment has not been won. The social planners—especially in Massachusetts—would have us under national health insurance.

Because of problems caused by the Medicare fiscal intermediary—Prudential—in issuing a flood of "medically unnecessary letters" late last year, your state medical society provided the AMA with the proof it needed to negotiate with HCFA for a change in its regulations requiring due process, establishment of criteria, and input from state medical societies. It still is too early to predict whether the agreement with HCFA will be honored and thus assure fair play.

The resignation of Arthur Krosnick, MD, as editor of *NEW JERSEY MEDICINE* created another challenge for your administrative team. The continued success of the journal of the Medical Society of New Jersey greatly depends on strong leadership. Howard D. Slobodien, MD, has taken on this endeavor and has served with distinction.

The commissioner of health, the president of the State Board of Medical Examiners, and the director of The PRO of New Jersey, Inc., have been invited to contribute educational articles to the magazine. A president's page has been added. There has been an attempt to recognize those physicians who have been honored and who have made outstanding contributions to the profession. *NEW JERSEY MEDICINE* continues to provide a high level of medical reporting with the commitment of its editor, the staff, the editorial board, and the Committee on Publication.

In an effort to broaden the participation of the counties and specialty societies, an invitation has been extended to these groups to be heard at the Board of Trustees' monthly meetings. Your officers, legislative representatives, and public relations consultants, are ready to address any meeting of the county societies. I personally have represented MSNJ 16 times in county societies, in 6 different states, and at a number of national meetings.

The Resource-Based Relative Value Scale has passed as a tentative means of reimbursement pending more complete modification. The Council on Medical Services is monitoring that issue since national organizations are planning a direct role. The Task Force on the Shortage of Nursing and Technical Personnel has been addressing problems in New Jersey. The Senior Citizens Task Force has been restructured to give more representation to local seniors.

An attempt has been made to make all councils, committees, and task forces and the AMA Delegation more accountable to the goals of the Medical Society of New Jersey. The Annual Meeting includes expanded educational sessions to respond to our duties in continuing education. The AIDS Task Force has worked diligently and consistently in providing continuing education to member physicians. The AIDS information booklet has been distributed to all members.

On the downside, collecting the mandatory assessment has continued to pose a problem. The Board of Trustees was faced with the loss of a substantial number of members who simply refused to pay the assessment. Even though the delinquent members should have been dropped from the Medical Society of New Jersey, the Board of Trustees voted to delete these individuals from the *Membership Directory* since they were not current in all their payments.

Membership in the Medical Society remains a problem. In the last five years, membership has increased only by 40 new members. Several counties have had serious membership losses (Essex County is down 199 members, and Hudson and Passaic counties lost 64 members and 26 members, respectively.) However, other county medical societies have had significant increases. To those counties who continued to show increases, I am deeply grateful for the work of the staff and the membership.

Three thousand letters to nonmember women physicians had a disappointing return. To give women physicians a forum, I established the Ad Hoc Committee on Women in Medicine chaired by Patricia Klein, MD. Percentage-wise, women physicians are the least involved physicians in organized medicine. This has serious implications for the future.

In an effort to address the problems of graduates of non-U.S. schools, the Ad Hoc Committee on Graduates of Non-U.S. Medical Schools was formed. The problem of discrimination in testing has been partially resolved by the ECFMG and more progress is forecast for the future.

While we are continuing to focus on membership recruitment, it must be remembered that our stand on peer review, ethical accountability, and continuing medical education, can make membership less than desirable for those who will not comply. However, we will continue to encourage membership for those who meet our standards.

It has been a good year, packed with challenges. I have no fears for the future. I trust fair winds and smooth sailing for the new skipper, Paul J. Hirsch, MD. H.A.D. Moltos Annos.

The Reference Committee recommended that the report be filed after correction of two minor typographical errors.

HOUSE ACTION: Adopted. The report was filed.

Judicial Council

PAUL H. STEEL, MD, CHAIRMAN

(Reference Committee "A")

The files of the Judicial Council continue to reflect overall efficiency in the statewide operation of the judicial mechanism. This year the volume of business lessened and the requests for appeal hearings were received sporadically; the cases were forwarded to the councilors for reply via telephone conference or certified mail, as to whether or not an appeal should be granted, thus reducing the necessity for the Judicial Council to convene for only one agenda item. Also, judicial committees functioning at the county level have been able to settle most grievances to the satisfaction of those concerned.

The Council is indebted to the judicial committees of the component societies for their command of operation and for their conscientiousness in regularly reporting all cases accepted for adjudication at the local level and the disposition made of them.

Of late, the Judicial Council has had a number of inquiries concerning lawful interest charges, attorney fees, collection expenses, and credit card costs. A March meeting has been scheduled to discuss the foregoing subjects. Any opinion that is developed from that meeting will be published in a Judicial Council supplemental report.

The Judicial Council presents the following résumé of its operations and those of county judicial committees for the period April 1988 through March 1989.

By Judicial Committees

Complaints reported as disposed of	83
Alleging:	
Dissatisfaction concerning fees	45
Dissatisfaction concerning medical procedures	18
Unprofessional conduct	8
Dissatisfaction concerning professional ethics	12

By Judicial Council

Meetings held	2
Official communications acted upon	145
Appeal hearings requested	3
Appeal hearings granted	0

The Reference Committee recommended that the report be filed.
HOUSE ACTION: Adopted. The report was filed.

Supplemental Report #1

Judicial Council

PAUL H. STEEL, MD, CHAIRMAN

(Reference Committee "A")

The Judicial Council of the Medical Society of New Jersey presents a summary of actions taken after compilation of its Annual Report.

REFERRALS FROM MSNJ/BOARD OF TRUSTEES (July 5, 1988)

- a. Resolution #7—*Confidentiality of Medical Information.*
- b. Resolution #8—*Unauthorized Release of Medical Information.*
- c. Resolution #11—*Telephone Information.*

These Resolutions, as well as the report of legal counsel were reviewed. The Council has adopted the following as the ethical standard for members of the Medical Society of New Jersey:

Medical information should be considered a confidential communication between the patient and his physician. A patient's medical information should not be given to others without the expressed authorization of the patient except in medical emergencies, or when there is imminent danger to others. All physicians are advised that for medical-legal reasons it is prudent to secure written documentation of the patient's authorization.

- d. Substitute Resolution #18—*Specialty Society Judicial Committee Review.*

"Resolved, that the Medical Society of New Jersey Judicial Council request specialty societies in New Jersey to provide expert reviewers to act in an advisory capacity to county judicial committees in cases involving quality of patient care."

The Judicial Council accepted Substitute Resolution #18 as informational and notes that expert review by specialty societies is available to county societies and can be processed through the Judicial Council upon request.

The Reference Committee recommended that Supplemental Report #1 be filed.

HOUSE ACTION: Adopted. The report was filed.

Supplemental Report #2

Judicial Council

PAUL H. STEEL, MD, CHAIRMAN

(Reference Committee "A")

The Judicial Council presents Supplemental Report #2, of action taken after compilation of its Annual Report and Supplemental Report #1.

Opinion of the Judicial Council: Interest Charges (officially adopted March 8, 1989).

A physician who has experienced problems with delinquent accounts may properly choose to add interest or other reasonable billing charges to delinquent accounts. The patient must be notified in advance of the interest or service charges by means of posting a notice in the waiting room, the distribution of leaflets in the office, and appropriate notations on billing statements. The physician must comply with state law which limits interest to the rate approved by the State Supreme Court. The rates may be obtained by calling the State Division of Investment at 609/984-4187. The approved rate changes annually. The rate for 1988 was 6 percent. The rate for 1989 is 7 percent. Physicians are encouraged to make exceptions in hardship cases.

The Council does not believe it is appropriate to add attorney's fees, court costs, or collection costs to the amount owed.

The Reference Committee recommended that Supplemental Report #2 be filed.

HOUSE ACTION: Adopted. The report was filed.

AMA Delegation

KARL T. FRANZONI, MD, CHAIRMAN

(Reference Committee "A")

I am pleased by the opportunity to report to you concerning AMA actions throughout the last year. The AMA House of Delegates is composed of 336 delegates representing state medical associations, 77 delegates representing national medical specialty societies, and 10 section and service delegates representing medical students, resident physicians, hospital medical staffs, young physicians, Army, Navy, Air Force, U.S. Public Health Service, and the Veterans Administration. This broad-based composition creates a unique forum for discussion and policy development of issues impacting upon the profession of medicine as it addresses the health care requirements of the American people. There is no comparable forum which brings together so many diverse interests and succeeds in the creation of communally acceptable policy pronouncements. The AMA House is abidingly democratic, in both substance and function. The AMA is deserving of continued enthusiastic support by all physicians.

ISSUES ADDRESSED DURING 1988

RBRVS—Resource-Based Relative Value Scale. The U.S. government has mandated modification of physician reimbursement under Medicare. The Harvard Hsiao study represents a collaborative effort to develop methodology to accomplish an equitable form of modification. Unless more resources are provided, this endeavor is intended to redistribute the physician payment component of health care financing. It is readily discernible that divisiveness is a predictable byproduct of such an effort. Quite surprisingly, at the Interim Meeting in Dallas during December 1988, Report AA represented a compromise vehicle with 19 recommendations. Favorable consideration for these recommendations could result in AMA support of RBRVS. Every effort should be expended to develop a unified policy by all factions of medicine regarding this issue. It is glaringly obvious that there will be economic advantage for some and disadvantage for others.

RCT—Registered Care Technologists. The AMA recommendation is to conduct a pilot study to evaluate the potential capacity of this career tract to materially improve the readily definable deficiencies in bedside patient care. This recommendation has incited substantial acrimony between medicine and nursing leadership. It is hoped that all involved will acknowledge the existence of deficiencies in bedside nursing care, and work together to evolve mutually agreeable solutions as expressed in Resolution #63, as amended:

Resolved, that the AMA, recognizing the concerns of our partners in health care, the nursing profession, work together with the American Nurses Association and other nursing organizations to address the nursing shortage, and continue to seek innovative ways to alleviate the acute shortage of bedside care providers; and that the Board of Trustees report to the House of Delegates at the Annual Meeting in 1989.

Oversight of Joint Ventures. Resolved, that the AMA oppose restrictions under consideration by the federal government that would prohibit physicians from referring patients to facilities in which they have an ownership interest; i.e. provided the principles embodied in Report A of the Council on Ethical and Judicial Affairs are applied.

Quality and Quantity of Medical School Applicants. There has been a dramatic decline in the number of applicants. There is consideration for the re-establishment of future physicians clubs. Physicians themselves denigrating the value of medical careers represents a significant portion of the problem.

Cholesterol Campaign. Will be receiving extensive public relations efforts.

Budget, Membership, and Dues. Approved the operating budget of \$189 million. Regular membership increased by 4,500. Annual dues increase of \$25, to \$400.

MSNJ RESOLUTIONS BEFORE AMA HOUSE OF DELEGATES

The following deals with resolutions introduced by the Medical Society of New Jersey into the AMA House of Delegates.

1. Graduates of Non-United States Medical Schools. The resolution proposed a policy statement whereby the AMA would oppose discrimination based on location of medical school and would strive to remove such discrimination in postgraduate education, licensure, and medical practice settings, such as hospital medical staffs.

The Reference Committee noted that the AMA has abundant policy opposing discrimination against foreign medical graduates. Testimony before the Reference Committee indicated that adoption of the resolution could be interpreted as advocating the avoidance of the requirement of the Educational Commission for Foreign Medical Graduates certificate for licensure and graduate medical education. It also was pointed out that adoption of the resolution could imply the approval of foreign medical schools that cannot be accredited, as are United States medical schools, by the Liaison Committee on Medical Education.

The following substitute resolution was adopted by the AMA House of Delegates:

Resolved, that the AMA continue to support the policy that all physicians and medical students be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character.

2. Medicare Deductibles and Copayments. This resolution called upon the AMA to petition the federal government to inform the public that physicians accepting Medicare assignment are required to bill for deductibles and copayments.

The Reference Committee heard testimony indicating that misinformation regarding the continued applicability of deductibles and copayments for Medicare assigned claims may be a significant impediment to the viability of ongoing efforts to maintain a voluntary approach to the assignment issue. The Reference Committee also heard testimony noting that copayments and deductibles may be waived in certain instances where billing and collecting for these items would not be practical, given such factors as the patient's financial status. The resolution was adopted, as amended, to read as follows:

Resolved, that the American Medical Association request the federal government to inform the public that physicians accepting Medicare assignment are required to make a reasonable attempt to bill for and collect deductible and copayment amounts.

3. Medicare Reimbursement Categories for Social Admissions and Continued Hospital Stays. New Jersey introduced a resolution at the 1988 AMA Annual Meeting in June calling for the AMA to petition Congress and the Health Care Financing Administration to include a Medicare hospital reimbursement category for humane social admissions and continued hospital stays.

The House also received a resolution calling for the AMA to work toward approval of "social admissions" for elderly or infirm Medicare patients temporarily in a state of compromised health, less acute than defined in the federal guidelines for inpatient admissions, but without significant personal independence or family or societal support.

Although the Reference Committee was aware that the Board of Trustees discussed the topic, the overwhelming testimony presented suggested that further study was necessary. As a result, the Reference Committee recommended that the two resolutions be referred to the Board of Trustees for report back. The Board in turn referred the resolutions to the Council on Medical Service for study.

In December, the Council on Medical Service responded to the resolutions addressing the unmet coverage needs of elderly Medicare patients including those who present for emergency care or outpatient care when needed nursing or followup services are not available; who no longer require care in an acute hospital setting but lack community followup services; and who are terminally ill and require hospital admission to provide respite for family caregivers. After considering changes to Medicare under the Catastrophic Coverage Act of 1988 and current AMA policy, the Council on Medical Service recommended that AMA policy support reimbursement under Medicare for short-term hospital admissions for medical reasons relating to diagnosis, stabilization, or treatment. However, the report suggested that reimbursement for hospital admissions for supportive or social services would be inappropriate under Medicare and should be addressed separately. The AMA House of Delegates adopted the report from the Council on Medical Service in lieu of the resolutions.

4. Equality of Testing. New Jersey introduced a resolution calling upon the AMA to request the National Board of Medical Examiners and the Educational Commission for Foreign Medical

Graduates to promptly administer a single test to all applicants for graduate medical education in the United States.

The Reference Committee heard testimony that the National Board of Medical Examiners has agreed in principle with the Educational Commission for Foreign Medical Graduates to make its Part I and Part II examinations available to candidates seeking ECFMG certification. The Reference Committee felt that the intent of the resolution is being accomplished and is not necessary. The Reference Committee noted further that graduates of medical schools accredited by the Liaison Committee on Medical Education are eligible for admission to accredited residencies without examination.

The resolution was not adopted.

5. Freedom of Choice for Residency Program Directors. New Jersey introduced a resolution asking the AMA to support two positions: (a) that candidates for residency programs be selected on the basis of qualifications and merit by local program directors and selection committees, and (b) that no governmental agency be allowed to impose financial restrictions that affect the composition of residents selected for accredited programs.

The resolution was not adopted. The Reference Committee observed that the AMA has consistently supported the selection of residents by program directors on the basis of merit and that a new policy is not required.

6. Repeal of PRO. The resolution called for the AMA to support efforts to repeal the federal peer review organization law.

The Reference Committee heard considerable testimony on the resolution, nearly all of it in opposition to the resolution. Opponents pointed to the lack of clear alternatives to the current PRO program, stated that repeal could invite a more active review role by individuals or entities more antagonistic to physicians' interests, and noted that a drive for repeal would be unrealistic and could damage the Association's credibility as a proponent of quality assurance. In addition, some speakers testified to improvements in PRO-physician relationships in their regions of the country.

The Reference Committee was sympathetic to the frustrations expressed by the proponents of the resolution. However, for the reasons cited, the Reference Committee felt that it was not an appropriate time to seek repeal of the PRO legislation. The resolution, therefore, was not adopted.

7. Location of Leadership Conferences. A resolution introduced by the New Jersey Delegation asked that the AMA schedule its National Leadership Conference in a city in the United States which is not subject to hazardous winter travel conditions.

Report AAA of the Board of Trustees informed the AMA House of Delegates that an evaluation of the location of the National Leadership Conference will be conducted following a three-year trial schedule in which the conference will be held in Chicago in 1989, and in locations with favorable climates in the east and west in 1990 and 1991.

The report of the Board of Trustees was adopted in lieu of the resolution.

CONCLUSION

Congratulations are in order for our MSNJ president, Doctor Palma E. Formica. She has assumed the role of chairman of the AMA Council on Long-Range Planning and Development.

All MSNJ elements once again are encouraged to sponsor and request local appearances by members of your AMA Delegation. Enhanced communications in both directions between the grassroots and the AMA is a goal worthy of aspiration, development, and accomplishment.

The Reference Committee recommended that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Committee on Long-Range Planning and Development

BERNARD ROBINS, MD, CHAIRMAN

(Reference Committee "A")

The Committee continued its ongoing efforts to enhance communication between the leadership of the Society and the general membership, and at its November meeting proposed several recommendations. The Committee will meet at least one more time before the Annual Meeting.

1. **County Society Forums.** The county society forum was put into effect February 1988. The Committee was requested to evaluate the effectiveness of the format. The Committee recommended that the format for inviting county societies to attend specific meetings of the Board be continued. It also recommended that county societies be asked to provide a list of the issues to be discussed at the forum, and to supply relevant data to assist in the deliberation of the issues. The Committee also recommended that county societies be encouraged to review issues at their monthly meetings so that their membership is informed and prepared to address the topics when presented to the Board at the county society forum.

The recommendations were approved by the Board of Trustees.

2. **Invitation to MSNJ Leadership To Attend County Society Meetings.** The Committee recommended that county medical societies be asked to extend an invitation to officers of the Medical Society of New Jersey, on a rotating basis, to meet with the leadership of the county at their monthly meetings for a discussion of issues. It was felt that a meeting with a small group would stimulate a meaningful dialogue and, as a result, be more productive. It was suggested that the format include a dinner meeting with the invited guest officer and the county society's council/board, followed by an open meeting with the general membership of the county.

The Board approved the recommendation.

3. **Resources Available to County Medical Societies.** The Committee was informed that MSNJ's legislative representatives are available to speak to county societies, but only one or two counties have extended invitations. The Board approved the recommendation of the Committee that, on a yearly basis, the presidents of county medical societies, medical specialty societies, and hospital medical staffs be notified of the people who are available through the Medical Society of New Jersey to speak on issues.

4. **Loss of Insurance Coverage by Physicians with Suspended or Revoked Licenses.** In accordance with Society policy, loss or suspension of a license by a physician member results in termination of his membership, thus cancelling the privilege of insurance coverage afforded to the membership. This item was considered and the Committee recommended that the Society adopt the position that when the cause for the suspension or retirement of member's license is verified as a physical or emotional illness, that member will be carried in the retired physician category and his eligibility for insurance coverage will continue through the Society's group plan. The recommendation was approved by the Board of Trustees.

The Reference Committee recommended that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Committee on Long-Range Planning and Development

BERNARD ROBINS, MD, CHAIRMAN

(Reference Committee "A")

1. **Membership Applications/Recruitment.** The Committee reviewed the implications of a five-year comparison study listing the total dues-paid membership of county medical societies. Although the study showed an overall increase of 40 members from December 31, 1983, to December 31, 1988, a decline in membership was apparent in three counties. A correlation between recruitment efforts and increased membership appears to exist.

A recommendation that each county medical society be requested to develop a membership recruitment program, with the understanding that the Medical Society of New Jersey would be ready to assist them in their endeavors whenever necessary, was approved by the Board of Trustees.

2. **Leadership and Orientation Program.** The Committee addressed the evident need for a program to assist new leaders in understanding and managing their responsibilities. A recommendation that a one-day orientation and leadership conference be held each June for county medical society and specialty society officers, and council and committee members was approved by the Board.

A recommendation requiring members of the Board of Trustees, members of the AMA delegation, and chairmen of councils and committees to attend the orientation and leadership conference at least once during their tenure was referred back to the Committee by the Board for further study.

3. **Special Assessment.** The negative effect of the \$100 special assessment approved for public relations purposes by the 1987 House of Delegates on membership retention prompted the Committee to review the Society's bylaw requirement regarding special assessments.

A proposed revision to Chapter X—Finance, Section 5—Special Assessments, was referred to the Committee on Revision of Constitution and Bylaws for consideration.

The Reference Committee recommended that Supplemental Report #1 be filed.

HOUSE ACTION: Adopted. The report was filed.

Committee on Physicians' Health

RONALD I. FORSTER, MD, CHAIRMAN

(Reference Committee "A")

Following are some of the activities of the past year:

1. **AMA 9th National Conference on the Impaired Physician.** The 9th National Conference on the Impaired Physician, sponsored by the AMA, was held in Chicago, Illinois. MSNJ was well represented this year as it was in the past by Dr. Canavan and Rev. Reading. The MSNJ program continues to enjoy the status of pacesetter and model program.

2. **Program Activities.** Program staff was increased by the addition of a second assistant director. Mr. Harry Myer, MEd, CAC, came on board in September 1988 to provide additional manpower to meet the needs of this ever-expanding service. Program participation continues to grow. There were 48 new cases in calendar 1988 that added to the already accumulated case-load of 414 physician clients. There has been increased awareness of the program at the hospital staff level. The program director, in association with the Medical Society leadership, has been involved in efforts to develop new legislation in response to the SCI report. Progress to date in this area seems promising.

3. **Statistical Summary.** A statistical illustration of our Program's activities from September 7, 1982, through December 31, 1988, follows:

	1982	1983	1984	1985	1986	1987	1988	Total
Primary Impairment								
Alcohol	14	40	19	31	31	17	15	167
Drugs	25	16	22	24	25	20	18	150
Psychiatric	7	18	19	19	14	15	9	101
Senility	1	5	3	2	—	—	1	12
Personality Disorder	—	1	—	—	2	1	—	4
Other	1	1	8	7	4	2	5	28
Annual Total	48	81	71	83	76	55	48	462
Degree								
MD	41	66	61	61	67	49	42	387
DO	6	10	3	9	4	1	4	37
DVM	—	1	3	4	—	1	—	9
Other	1	4	4	9	5	4	2	29
Annual Total	48	81	71	83	76	55	48	462
Total male clients								417
Total female clients								45
Total all clients								462

4. **Treatment Loan Fund.** The Physicians' Health Program continues to provide low-interest loans to physicians and/or their families based on demonstrated need to cover treatment and/or living expenses. The status of the Treatment Loan Fund is as follows:

Fund Balance 1/1/88	\$32,851.31
Repayment of Principal	5,996.79
Interest on Loans	672.85
Donations	2,321.00
Interest on Fund	8,508.00
Other	600.00
	\$50,949.95
Loans Issued 1988	(14,749.00)
Fund Balance 1/1/89	\$36,200.95
Total Outstanding Loans	\$29,095.69
Total Fund Value to 1/1/89	\$65,296.64
(current balance + outstanding loans)	

From January 1, 1988, to January 1, 1989, nine new loans were issued to the total of \$14,749.00.

Currently, 18 physicians are recipients of funds from the Treatment Loan Fund.

5. **Annual Raffle.** The 1988 Annual Raffle was held on May 31, 1988, at MSNJ headquarters. Gross receipts from the raffle amounted to \$40,687. Expenses incurred relating to the raffle were \$14,181.33. The total net proceeds added to the Grant Fund was \$26,505.67. At the time of this writing, the 1989 Annual Raffle activities have begun.

6. **Grant Fund.** This fund continues to operate as a fund by which physicians and/or their families can benefit from monies made available to them on the basis of need as a result of the annual raffle sponsored by the Auxiliaries to the New Jersey Association of Osteopathic Physicians and Surgeons and the Medical Society of New Jersey. The status of the Grant Fund is as follows:

Total Grants Issued 1986-88	\$30,925.00
-----------------------------------	-------------

To date, there have been a total of 29 grants issued to 21 physicians.

7. **1988 Adopt-A-Family Program.** Because of the success of the past Adopt-A-Family programs and because of the need for such a program, once again this year Program staff solicited the assistance of MSNJ's Board of Trustees, county medical societies, county auxiliaries, the NJAOPS, and its Auxiliary for this holiday program. A total of \$4,835 was raised and distributed as a result of this program. In addition, gift items were dropped off at our offices by physicians and auxiliaries for distribution. From the monies collected, cash gifts were distributed to four physicians and their families. These included both MDs and DOs. Thirteen children received Christmas and Chanukah gifts in time for the holidays. Six families were recipients of food baskets. The gifts were purchased with the money received from donations. Food baskets were made up from food which was donated by physicians and auxiliaries. Also, food baskets were delivered by auxiliaries.

8. **Protocol for Handling Referrals from the State Board of Medical Examiners of Cases Without a Diagnosable Illness.** The Board of Trustees adopted the protocol presented by the Committee establishing guidelines to be followed when the State Board of Medical Examiners makes a referral to the PHP which culminates in the individual not having a treatable diagnosis.

9. **Urine Monitoring Program.** Staff has revised the urine monitoring program and distributed guidelines to monitors throughout the state.

The Reference Committee recommended that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Resolution #9

Introduced by: Middlesex County Medical Society
Subject: Sexual Misconduct
Referred to: Reference Committee "A"

Whereas, concern has been expressed by the resident section and medical student section of the American Medical Association that sexual harassment and exploitation exists in the training of physicians and thereby appears to adversely affect both patient care and the learning experience; and

Whereas, there appears to be an uncertainty as to the expected standard of conduct in teaching and professional relationships; and

Whereas, the tradition of the AMA Principles of Medical Ethics, as well as the recent opinion of the AMA Council on Ethical and Judicial Affairs (AMA House of Delegates Proceedings, December 1986, page 229), have stated that sexual misconduct in the practice of medicine is unethical; and

Whereas, there is a fiduciary responsibility in the teacher-student relationship; and

Whereas, sexual harassment and exploitation are illegal; now therefore be it

~~Resolved, that the Medical Society of New Jersey petition the American Medical Association to reaffirm that sexual misconduct in patient care, teaching, and other professional relationships is unethical and unprofessional.~~

The Reference Committee recommended that Resolution #9 be amended to read as follows:

Resolved, that the Medical Society of New Jersey affirms that sexual exploitation in patient care, teaching, and other professional relationships is unethical and unprofessional.

HOUSE ACTION: The Reference Committee recommendation was not adopted. Substitute Resolution #9 was adopted by the House of Delegates.

Substitute Resolution #9 Sexual Exploitation

Resolved, that the Medical Society of New Jersey reaffirm that sexual exploitation in teaching and other professional relationships is unethical and unprofessional, and at the appropriate time petition the AMA to so reaffirm.

Resolution # 10

Introduced by: Burlington County Medical Society
Subject: Medicare Assignment—Resource-Based Relative Value Scales
Referred to: Reference Committee "A"

Whereas, there is increasing government pressure to reduce medical costs; and

Whereas, the present customary, prevailing, and reasonable fee schedule is considered to emphasize procedure-oriented services over cognitive services; and

Whereas, the medical profession is not in full agreement with the proposed resource-based relative value scales (RBRVS); and

Whereas, the AMA supports the physician's right to decide on a claim-by-claim basis whether or not to accept Medicare assignment, and opposes the elimination of balance billing; and

Whereas, the AMA supports voluntary assignment programs for low-income Medicare beneficiaries; now therefore be it

~~Resolved, that if federal legislation moves toward accepting some form of resource-based relative value scales for physician payment, the AMA petition the federal government to mandate that no state be allowed to legislate that physicians' acceptance of Medicare assignment be a requirement for medical licensure.~~

The Reference Committee recommended that Resolution #10 be amended to read as follows:

Resolved, that the AMA petition the federal government to mandate that no state be allowed to legislate that physicians' acceptance of Medicare assignment be a requirement for medical licensure.

HOUSE ACTION: The Reference Committee recommendation was not adopted. Substitute Resolution #10 was adopted by the House of Delegates.

Substitute Resolution #10

Mandatory Medicare Assignment as a Requirement of Licensure

Resolved, that the Medical Society of New Jersey continue its unalterable opposition to mandatory acceptance of Medicare assignment by physicians; and be it further

Resolved, that the AMA delegation request the AMA to petition the federal government to mandate that no state be allowed to legislate that physicians' acceptance of Medicare assignment be a requirement for medical licensure.

Resolution #19

Introduced by: John Winslow, MD, Delegate, Essex County
Subject: MSNJ Policy on Abortion
Referred to: Reference Committee "A"

Whereas, again there is much controversy concerning a woman's right to choose an abortion if she so desires, with a very vocal minority opposing all abortions, no matter for what cause, seemingly worrying more about the fetus than the pregnant woman; and

Whereas, it is a known fact that abortions will continue to be performed no matter what the prevailing legal status might be; and

Whereas, clandestine "illegal" abortions in the past proved to be very dangerous with a significant morbidity and even mortality, and safely performed ones were out of the financial reach of those who most needed them; and

Whereas, abortions are not the preferred form of birth control, but there are occasions when it becomes the only available form; and

Whereas, countless thousands of abortions have been performed safely with almost no morbidity nor mortality since the laws were changed to permit their safe performance; and

Whereas, any adverse psychological effects on the woman having an abortion have proved to be minimal, particularly after the passage of time, and the chief problem now appears to be the necessity of having to run the gauntlet of obstructive protesters outside of clinics; and

Whereas, the government's withdrawal of support for Planned Parenthood and other pregnancy counselling services—those which dare to mention "abortion" as one of the alternatives—has had a devastating effect on active counselling for those women who most need it; and

Whereas, the studies of genetics along with newer technologies based on amniocentesis have been able to pick up significant fetal anomalies at an early stage, so that undesirable fetuses do not have to go to term to have the unhappy discovery of grave defects; and

Whereas, pregnancies that have resulted from rape or incest can be safely interrupted without having to go through some subterfuge that a D & C is needed for the woman's health, as was formerly the case; now therefore be it

~~Resolved, that the House of Delegates readopt the following policy:-~~

~~1) The Medical Society of New Jersey supports a woman's right to have an abortion performed, provided it is done by a physician in a timely and safe manner, under the guidelines set by the Board of Medical Examiners.~~

~~2) No physician or hospital shall be required to perform abortions when it is against their beliefs or will.~~

~~3) The Medical Society of New Jersey supports and encourages the introduction into the United States of RU486, the new "contragestation" medication that safely interrupts early pregnancies, without surgical abortion.~~

~~4) The Medical Society of New Jersey will oppose any legislative or judicial restrictions to the above policies supporting the right to abortion.~~

While sympathetic to some of the goals set forth in Resolution #19, the Reference Committee felt it had addressed the Medical Society position on abortion in Resolution #28.

The Reference Committee recommended that Resolution #19 be rejected.

HOUSE ACTION: *The Reference Committee recommendation was adopted. Resolution #19 was rejected.*

Resolution #28

Introduced by: Charles J. Moloney, MD, Delegate, Burlington County
Subject: MSNJ Position on Abortion
Referred to: Reference Committee "A"

Whereas, the current Medical Society of New Jersey policy regarding abortion asserts there are no moral or ethical considerations about this procedure and specifically mentions a stigma being attached to pregnancy; and

Whereas, the current Medical Society of New Jersey policy was made when governmental and academic experts were falsely forecasting a superfluity of unwanted births and advocated abortion as a means to counteract this nonexistent problem; and

Whereas, the number of live births has been well below the replacement rate nationally and is particularly low in New Jersey, and babies again are being considered precious instead of a threat to the environment and to our way of life; and

Whereas, abortion was considered unethical and immoral from the time of Hippocrates; and

Whereas, a very large minority of Medical Society of New Jersey members consider abortion akin to murder; and

Whereas, certain abortions (such as to annihilate somebody who has trisomy 21) are an especially crude and primitive form of disease control; now therefore be it

~~**Resolved,** that the Medical Society of New Jersey recognize that there are profound moral considerations involved in abortion, and that since experts on morals disagree on this matter, the Medical Society of New Jersey should rescind its previous stance on abortion and refrain from taking a position in this matter.~~

The current Medical Society of New Jersey policy on abortion was adopted by the House of Delegates on May 8, 1972. Many of its guidelines no longer are meaningful or applicable.

The Reference Committee recommended that Resolution #28 be amended to read as follows:

Resolved, that since the Medical Society of New Jersey recognizes that there are profound moral controversies involved in abortion, it should rescind its previous stance on abortion and take no position at this time.

HOUSE ACTION: *The Reference Committee recommendation was not adopted. Substitute Resolution #28 was adopted instead.*

Substitute Resolution #28 MSNJ Position on Abortion

Resolved, that the Medical Society of New Jersey, while recognizing that there are profound moral considerations involved in abortion, does not oppose a woman's right to have an abortion performed, provided it is done by a physician in a timely and safe manner, under the guidelines previously set by the State Board of Medical Examiners.

Resolution #31

Introduced by: Union County Medical Society
Subject: Collective Bargaining
Referred to: Reference Committee "A"

Whereas, physicians are at a serious disadvantage in negotiating with health insurers, HMOs, and other third-party carriers; and

Whereas, the intrusion of these carriers and their managed care programs have adversely affected both patient care and professional judgment; and

Whereas, current antitrust laws make it impossible for physicians to effectively and collectively bargain with these corporate monoliths; now therefore be it

Resolved, that the Medical Society of New Jersey draft and seek the introduction and passage of legislation that will enable private practitioners to collectively bargain under state law; and be it further

Resolved, that the Medical Society of New Jersey request the AMA to seek the necessary amendments to federal law to permit private practitioners to engage in collective bargaining.

The extremely high cost of changing legislation, coupled with the low probability of success for such efforts, influenced the opinion of the Reference Committee.

The Reference Committee recommended that Resolution #31 be rejected.

HOUSE ACTION: *The recommendation of the Reference Committee was not adopted. Resolution #31 was adopted.*

Secretary

BERNARD ROBINS, MD

(Reference Committee "B")

The office of the secretary has continued its usual routines, primarily involving maintenance of membership records, correspondence, minutes of Board of Trustees' meetings, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the administrative year, the secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

Membership (as of December 31, 1988)

Active:	Paid	7,567	
	Exempt	846	
Resident	Paid	210	8,623***
*Associate:	Paid	62	
**Affiliate:	Paid	95	
	Exempt	5	
State Emeritus			1,040
Total of above			<u>9,825</u>
Provisional Residents (six months)			16
State Honorary			1
New and Reinstated Members:			
Active			632
Resident			92
*Associate			42
**Affiliate			2
Transfers within the state			58
Transfers out-of-state and resignations			111
Members deceased			156
Members dropped			260

Active:			
a. Nonpayment of dues		163	
b. Did not comply with bylaw requirements regarding continuing medical education, whose credits were due in 1986		25	
c. New Jersey license suspended		3	
d. New Jersey license temporarily suspended		2	
e. New Jersey license permanently surrendered		1	
f. New Jersey license revoked		1	
Resident (nonpayment of dues)		35	
*Associate (nonpayment of dues)		23	
**Affiliate (nonpayment of dues)		7	
*Associate membership (nonlicensed in New Jersey) designates interns and residents.			
**Affiliate membership physicians who no longer practice in New Jersey.			
***Adjusted for transfers out-of-state, resignations, and deaths.			

A comparison of December 31, 1987, to December 31, 1988, by county shows the following net changes of active paid membership:

Atlantic	+ 6	Gloucester	+ 1	Ocean	+18
Bergen	- 3	Hudson	-17	Passaic	+ 5
Burlington	+ 4	Hunterdon	- 4	Salem	- 1
Camden	+ 8	Mercer	- 3	Somerset	+ 6
Cape May	- 1	Middlesex	+18	Sussex	- 2
Cumberland	- 1	Monmouth	- 1	Union	+ 4
Essex	-42	Morris	+ 1	Warren	+ 4

AMA Membership. A total of 9,716 New Jersey licensed physicians maintain active membership in the AMA. The Society's representation in the AMA House of Delegates stands at ten delegates—one for each thousand members, or fraction thereof.

Credentials. The Committee on Credentials throughout the year reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies. The statistical breakdown in the Table reflects the Committee's activities during the period February 15, 1988, through January 31, 1989.

	<u>Provisional Residents</u>		<u>Active</u>	<u>Grand Total</u>
	<u>*Associate</u>	<u>Licensed</u>		
Received:	48	77	385	510
	<u>Provisional Residents</u>		<u>Active</u>	<u>Grand Total</u>
	<u>*Associate</u>	<u>Licensed</u>		
Reviewed and found:				
(A) Satisfactory	46	73	354	473
(B) Unsatisfactory	0	0	0	0
Pending:	1	4	7	12
Withdrew:	1	0	24	25
Grand Total	<u>48</u>	<u>77</u>	<u>385</u>	<u>510</u>

*Associate membership (nonlicensed in New Jersey) designates interns and residents.

The Committee extends appreciation to the directors and the secretaries of component societies, and to those who assist them, as well as the County Credentials Committees, for their cooperation in processing membership applications. It especially would be helpful to the Credentials Committee of the Medical Society of New Jersey if those who process credentials in the component societies would call specific attention to any deficiencies or questionable data being submitted on the application form. This procedure will help insure more accurate and speedy evaluation of credentials. The chairman wishes to thank his committee members for their diligence and cooperation.

Membership Directory. The 1989 edition of the *Membership Directory* has been completed and distributed to all members. As a result of increased costs it was necessary to increase the sale price to \$65 (plus tax) per copy. Additional copies of the *Membership Directory* are available, for a fee, by contacting Mrs. Guest at MSNJ headquarters, Lawrenceville. There were 2,437 copies of the 1987 edition sold to nonmembers.

The Reference Committee recommended that the report be filed with special commendation to Arthur White, MSNJ's Director, Finance and Administrative Services.

HOUSE ACTION: Adopted. The report was filed.

Treasurer

JOSEPH N. MICALE, MD

(Reference Committee "B")

These interim financial statements, prepared in accordance with generally accepted accounting principles, reflect the financial position and results of operation of the Medical Society of New Jersey through January 31, 1989.

Since they are interim statements (the Society's fiscal year is June 1-May 31) the figures are unaudited. A complete audit will be conducted of the books of the Society as of May 31, 1989, and an audited report prepared as of that date. A complete audit was made, and copies sent to all county medical societies, as of May 31, 1988.

*Medical Society of New Jersey
Balance Sheet
January 31, 1989
(Unaudited)*

Assets

Cash		\$ 38,553
Investment in money market fund		462,286
Marketable securities—(approximate market)		2,994,957
Accounts receivable—member assessments		879,200
Medical Student Loans (net allowance for doubtful loans of \$20,000)		271,460
Property, Plant, and Equipment		
Land	\$ 150,000	
Building and improvements	2,551,229	
Furniture and fixtures	522,794	
	<u>3,224,023</u>	
Less allowance for depreciation	(913,826)	2,310,197
Prepaid expenses		92,500
Other assets		<u>175,157</u>
		<u>\$7,224,310</u>

Liabilities and Fund Balance

Accounts payable and accrued expenses	\$ 413,147
Assessments collected for AMA	<u>81,130</u>
	494,277
Mortgage payable	1,376,771
Deferred revenue from member assessments	2,406,250
Deferred revenue—Public Relations Assessment	435,300
Deferred revenue—other	195,803
Fund Balance	<u>2,315,909</u>
	<u>\$7,224,310</u>

*Medical Society of New Jersey
Statement of Revenue and Expenses
8 Months Ended January 31, 1989
(Unaudited)*

Revenue

Membership Dues	\$1,582,173
Publication sales and advertising income	219,333
Amortization of Physicians' Health Program	152,135
Amortization of Public Relations Assessment	65,606
Investment income	103,931
Royalty income	175,758
Rental income	95,804
Annual Meeting	30,013
Other income	84,800
Total Revenue	<u>2,509,553</u>

Expenses

Conferences and Meetings	565,774
Member Services	568,266
Total Program Expenses	<u>1,134,040</u>
General and Administrative	1,161,823
Interest	92,580
Depreciation	84,466
Total Expenses	<u>2,472,909</u>

Excess of Revenue over Expenses	\$ 36,644
Fund Balance at June 1, 1988	<u>2,279,265</u>
Fund Balance at January 31, 1989	<u><u>\$2,315,909</u></u>

**The Reference Committee recommended that the report be filed.
HOUSE ACTION: Adopted. The report was filed.**

Committee on Finance and Budget

MATIS A. FERMAGLICH, MD, CHAIRMAN

(Reference Committee "B")

The Committee on Finance and Budget met on Thursday, March 23, 1989, for the purpose of reviewing the proposed budget for the 1989-1990 fiscal year. The proposed budget and the following recommendations were approved by the Board of Trustees on April 9, 1989, and are submitted to the House of Delegates for approval.

RECOMMENDATIONS

1. That future attendance at AMA Leadership Conferences be limited to ten members selected by the president, in consultation with the chairman of the AMA Delegation. A predetermined stipend to be paid to each attendee for expenses. (*Current policy provides for AMA delegates and alternates to attend at Society expense. MSNJ also absorbs the registration fee of those trustees desiring to attend the meeting.)
2. That reimbursement of expenses to AMA delegates and alternates for attendance at AMA annual and interim meetings be based on a predetermined stipend per physician, per meeting.
3. That the budget for the fiscal year beginning June 1, 1989, and ending May 31, 1990, in the amount of \$3,949,000 with \$2,261,000 to be raised through member assessments be adopted.
4. That the 1990 assessment be set at \$350 per regular dues-paying member. (No change from prior year.)
5. That the 1990 assessment be set at \$60 per member for affiliate members (no longer practicing in New Jersey). (No change from prior year.)
6. That the 1990 assessment for associate members (interns-residents nonlicensed in New Jersey) and licensed residents, provided the individual is in a residency program entered upon within a reasonable time after his or her graduation from medical school, be set at \$25. (No change from prior year.)
7. That the 1990 assessment be set at \$10 per student for medical students. (No change from prior year.)

**Medical Society of New Jersey
Statement of Revenue and Expenses
Proposed Budget
Fiscal Year Ending May 31, 1990**

Revenue (other than member assessments)

Publication sales and advertising income	\$ 245,000
Amortization of Physicians' Health Program	237,000
Amortization of Public Relations Assessment	200,000
Investment income	130,000
Royalty income	259,000
Rental income	555,000 ¹
Annual Meeting	10,000
Membership Directory sales	40,000
Other income	12,000
Total Revenue	<u>\$1,688,000</u>

Expenses

Conferences and Meetings	531,000
Member Services	569,000
Publications	319,000
Total Program Expenses	<u>\$1,419,000</u>
General and Administrative	1,996,000
Interest	367,000
Depreciation	167,000
Total Expenses	<u>\$3,949,000</u>

Amount of expenses over revenue to be raised through member assessments (including <i>NEW JERSEY MEDICINE</i> subscriptions and Annual Meeting assessments)	<u><u>\$2,261,000</u></u>
---	---------------------------

**Revenue from Member Assessments
Fiscal Year Ending May 31, 1990**

\$350 x 7,400 members	<u><u>\$2,590,000</u></u>
-----------------------	---------------------------

¹Includes \$270,000 amortization of construction loan.

Medical Society of New Jersey
Proposed Budget: Fiscal Year Ending May 31, 1990

	Approved Budget 1988/89	Estimate for Y/E 5/31/89	Proposed Budget 1989/90
Compensation			
Salaries	\$1,002,000	\$1,014,000	\$1,080,000
Pension Plan	117,000	99,000	102,000
	<u>1,119,000</u>	<u>1,113,000</u>	<u>1,182,000</u>
Professional Fees			
Audit	20,000	25,000	21,000
Legal	45,000	45,000	50,000
Actuarial	3,000	3,000	3,000
Special Consultants	15,000	11,000	10,000
	<u>83,000</u>	<u>84,000</u>	<u>84,000</u>
Councils and Committees			
Public Relations	250,000	250,000	250,000
Public Relations—Special Assessment	200,000	200,000	200,000
Legislation	80,000	80,000	88,000
President and Presidential Officers	70,000	77,000	75,000
AMA Delegates	85,000	75,000	87,000
MSNJ Auxiliary	25,000	25,000	25,000
Medical Education	35,000	33,000	35,000
Board of Trustees	35,000	30,000	35,000
Judicial Council	1,000	1,000	1,000
Reimbursement of representatives to meetings	3,000	3,000	3,000
Other Councils and Committees	50,000	45,000	50,000
Medical Student Association	15,000	10,000	12,000
Grant Allocation—NJSMU	—	—	(330,000)
	<u>849,000</u>	<u>829,000</u>	<u>531,000</u>
Member Services			
Physicians' Health Program	335,000	335,000	342,000
Annual Meeting	120,000	110,000	120,000
Professional Liability	45,000	45,000	52,000
Membership Directory	55,000	50,000	55,000
	<u>555,000</u>	<u>540,000</u>	<u>569,000</u>
Publications			
<i>NEW JERSEY MEDICINE</i>	<u>282,000</u>	<u>302,000</u>	<u>319,000</u>
General Administrative and Operating Expenses			
Building operations—including depreciation	437,000	409,000	701,000
Insurance	158,000	166,000	184,000
Payroll taxes	73,000	76,000	80,000
Other general office cost	194,000	186,000	299,000
	<u>862,000</u>	<u>837,000</u>	<u>1,264,000</u>
Total	<u>\$3,750,000</u>	<u>\$3,705,000</u>	<u>\$3,949,000</u>

The Reference Committee recommended approval of recommendations 1 through 7.

HOUSE ACTION: Adopted. The recommendations were approved.

The Reference Committee recommended the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Council on Mental Health

CHURCHILL L. BLAKEY, MD, CHAIRMAN

(Reference Committee "B")

The Council on Mental Health met September 28, 1988, (reorganization) and January 25, 1989. We supported the Medical Society of New Jersey making available to the State Board of Medical Examiners, consultants recommended by the New Jersey Psychiatric Association.

The Council communicated its evaluation on several bills as requested by the Council on Legislation. These concerned implementation of and derivative regulations from the state's new psychiatric commitment law and community-based acute interventional assessment units. Concerns over maintaining continuum of care and adequate staffing and funding of these new units dominated our discussions.

The Council recommended to the Board of Trustees that it incorporate into its public relations program in 1989 three 30-second public service video messages produced by the Washington Psychiatric Society on teen suicide, depression, and panic anxiety disorders to be coordinated through the New Jersey Psychiatric Association. The Board of Trustees, at its meeting on October 16, 1988, referred the recommendation to the Council on Public Relations for consideration, study, and possible implementation with the New Jersey Psychiatric Association providing staffing for a toll-free, instate response number.

Our Council became aware of frictional issues between psychologists and psychiatrists regarding psychologists' institutional admission privileges and possible prescribing privileges. We agreed to support current AMA initiated efforts to preclude costly demonstration projects to test prescribing feasibility in a military situation.

Finally, and not conclusively, we grappled with the destructive reimbursement inequality of mental health service benefits to institutions and physicians alike. Studies over a variety of cultures and nationalities have shown that monetary expansion of insurance benefits and premium costs to the point of equality will have its payback by the fourth year in prevention of deferred, more extensive and devastating mental illness. Several New Jersey Senate bills address this situation. Education of our Council members with specific implementation strategies will occur. Our next meeting will be on May 31, 1989.

The Reference Committee recommended that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Council on Public Health

CHARLES J. MOLONEY, MD, CHAIRMAN

(Reference Committee "B")

1. **Educational Seminar on Counseling HIV Positive Patients.** Upon reviewing the seminar on AIDS conducted on March 16, 1988, by the Academy of Medicine of New Jersey, the Council recommended to the Board of Trustees that an additional seminar should be held focusing on the counseling of patients who are HIV positive. The Board referred the recommendation to the Task Force on AIDS for input and implementation. It was determined by the AIDS Task Force that there is no need for additional programs on counseling at this time. Information regarding counseling HIV positive and AIDS patients currently is being worked on or already is available.

2. **Eye Health Screening Program.** The Board of Trustees, at its meeting on June 12, 1988, approved the following recommendations submitted by the Council to be adopted as Medical Society policy with regard to the Eye Health Screening Program sponsored by the Medical Society of New Jersey and conducted annually through the Committee on Conservation of Vision:

a. That the Eye Health Screening Program be conducted only at hospital locations, mobile units operated by the New Jersey Commission for the Blind and Visually Impaired, and certain New Jersey Department of Health sites which will not benefit private entrepreneurs.

b. That the Eye Health Screening Program be medically oriented, and that it be conducted only by ophthalmologists.

The annual Eye Health Screening Program was held the week of September 26, 1988, with 5,567 persons being screened. Out of that total, 328 glaucoma suspects were found.

3. **Department of Health—Silicosis and Occupational Asthma.** The Council agreed to assist Commissioner of Health Molly Coye, MD, in disseminating information and encouraging the Society's membership to participate in a project being formulated whereby silicosis and occupational asthma would be reported.

4. **Implantable Infusion Pump for Chronic Pain.** The Board of Trustees approved a recommendation submitted by the Committee on Cancer Control that the Society urge the Department of Insurance to require insurance carriers to recognize the implantable infusion pump as being valid for reimbursement purposes when used for the intrathecal or epidural administration of medication for the treatment of intractable pain.

5. **Inspection of Incinerators.** Upon meeting with representatives of the New Jersey Department of Environmental Protection and a company involved in resource conservation and controlled air incineration, the Committee on Environmental Health recommended that the Board of Trustees urge the New Jersey Department of Environmental Protection to review all incinerators, including those at hospitals, to insure their compliance with appropriate air quality standards. The Board of Trustees approved this recommendation at its meeting on November 20, 1988, and commended the Committee on Environmental Health and the Council on Public Health for their initiative in this area.

6. **Environmental Health Conference.** Because of a number of timely issues in the area of environmental health which directly impact upon the state, ie, radon, medical waste incineration, and ocean pollution, the Committee on Environmental Protection recommended to the Board of Trustees that the Academy of Medicine of New Jersey be asked to conduct a conference in conjunction with MSNJ on topics of current interest in the area of environmental health. The Board of Trustees, at its meeting on November 20, 1988, approved the recommendation and suggested that the conference be held during the Society's 1989 Annual Meeting.

The Reference Committee recommended that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Committee on Annual Meeting

ANGELO S. AGRO, MD, CHAIRMAN

(Reference Committee "B")

In 1987, the House of Delegates approved the recommendation that the Committee on Annual Meeting consider the Meadowlands Complex and Resorts Taj Mahal Casino Hotel, in Atlantic City, for the 1989 and 1990 Annual Meetings.

The Committee was advised that Resorts Taj Mahal Casino Hotel will not be completed until late 1989 or early 1990, and other facilities contacted in Atlantic City are unable to satisfy MSNJ's meeting requirements.

At its meeting on September 18, 1988, the Board of Trustees approved the recommendation that the 1989 Annual Meeting be held at the Sheraton Meadowlands Hotel in East Rutherford.

The daily schedule for Thursday has been revised. Specific changes are: the opening session of the House of Delegates will convene at 10:00 A.M. instead of 2:00 P.M., and inclusion of educational programs from 1:00 P.M. to 3:00 P.M.

The 1989 House of Delegates will meet on three consecutive days, beginning with its opening session on Thursday morning, April 27. The election will be held on Friday, April 28, and the last session of the House will be held on Saturday. Reference committees are scheduled to meet on Thursday and Friday afternoons (April 27 and 28). The inaugural reception and dinner-dance honoring President-Elect Paul J. Hirsch, MD, will be held on Saturday, April 29.

The symposium scheduled for 1:00 P.M., Thursday, April 27, will be, "Clinical Trials in HIV Infection: What To Do When the HIV Test Is Positive" and will be cosponsored by the Academy of Medicine of New Jersey, the Division of AIDS Prevention and Control of the New Jersey State Department of Health, and the Medical Society of New Jersey.

An educational program scheduled for 1:00 P.M., Thursday, April 27, and cosponsored by the New Jersey Society of Internal Medicine and the New Jersey Chapter, American College of Surgeons, will be entitled "Diagnosis and Management of Dissecting Aneurysm/Medical-Surgical Viewpoint."

The general session scheduled for 8:30 A.M., Sunday, April 30, will be on topics of current interest in the area of environmental health.

We believe you will find the programs informative and provocative.

JEMPAC's Political Forum will be at 5:00 P.M., on Friday, April 28, followed by the JEMPAC Wine & Cheese Reception at 5:45 P.M.

The management of the hotel granted permission to have 22 exhibits in the hallway on the second floor—the location for all meetings and functions.

The Message Center will be sponsored by the New Jersey Society of Medical Assistants.

The Advance Convention Program was mailed in March.

Housing applications were sent to all component medical societies, and copies have appeared in *NEW JERSEY MEDICINE*, the journal of the Medical Society of New Jersey.

The Committee will evaluate the commitment and completion date of the Taj Mahal Casino Hotel in Atlantic City, along with the Sheraton Meadowlands Hotel in East Rutherford for the 1990 and 1991 Annual Meetings. A two-year commitment will be considered if arrangements would be advantageous to the Society. With the approval of the Board of Trustees, a report advising the site and date for the 1990 and 1991 Annual Meetings will be circulated to all component medical societies, and will appear in *NEW JERSEY MEDICINE*.

The Reference Committee recommended that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Nominations for Emeritus Membership

(Reference Committee "B")

The following nominations for election to emeritus membership at the 1989 Annual Meeting have been received from the component societies. Conforming to the provisions of the Bylaws, Chapter I—Membership, Section 1—Composition (d), all nominees have been members in good standing of a component society and who by reason of age or infirmity have retired from the active practice of medicine, or members of this Society who have been disabled by reason of military service.

Atlantic County

James F. Gleason, MD, Ventnor; age 71
Edwin S. Woolbert, MD, Pleasantville; age 71

Bergen County

Gerald F. Dederick, Jr, MD, Ho-Ho-Kus; age 72
Stradford T. Draesel, MD, Miami Shores, Florida
(formerly Hasbrouck Heights); age 69
Eugene Gersh, MD, Valparaiso, Indiana
(formerly Fort Lee); age 65
Vincent W. Giudice, MD, Waldwick; age 77
Jesse D. Greenberg, MD, Tenaflly; age 63
Peter G. Hunziker, MD, Teaneck; age 76
Abraham Katz, MD, New York City, New York
(formerly Fair Lawn); age 77
Donald J. Kissinger, MD, Teaneck; age 80
Samuel Loman, MD, Cresskill; age 83
Victor Romano, MD, Teaneck; age 75
Rafael M. Sanchez, MD, Englewood; age 69
Hanfred R. Seela, MD, Wyckoff; age 64

Burlington County

Robert M. Cohen, MD, Philadelphia, Pennsylvania
(formerly Willingboro); age 50
Harris G. Fister, MD, Maple Shade; age 67
Benjamin R. Paradee, MD, Haddonfield; age 65
John R. Wolgamot, MD, Moorestown; age 69

Camden County

Wallace B. Hussong, MD, Merchantville; age 70
Ralph A. Onofrio, MD, Cherry Hill; age 68
Rowan C. Pearce, Jr, MD, Haddonfield; age 69
Edwin R. Rosner, MD, Haddonfield; age 81

Essex County

George P. Bisgeier, MD, Cranbury; age 65
Enio F.U. Calluori, MD, Caldwell; age 63
Harvey P. Einhorn, MD, Florham Park; age 71
Salvatore J. Giarratano, MD, Wyckoff; age 66
Jack Grundfest, MD, Belleville; age 72
Agostino R. Pugliese, MD, Fairfield; age 66
Robert E. Rich, MD, Lakewood; age 69
Irving L. Sperling, MD, Roseland; age 74

Richard U. Stern, MD, West Orange; age 67
Peter Tarakajian, MD, Hackensack; age 70
Charles V. Tierney, MD, Maplewood; age 66
Lester Weissman, MD, West Orange; age 67

Gloucester County

Frederick J. Faux, MD, Woodbury; age 79
Thomas Mervine, MD, Haddonfield; age 75
Ralph L. Moore, MD, Woodbury; age 82

Hudson County

Conrad M. Bahnson, MD, Chatham, New York; age 88
Edward N. Bookrajian, MD, Tenaflly; age 85
Clement M. Jones, MD, Cranbury; age 81
David Osterreicher, MD, Kiryat Tivon, Israel; age 88
Joseph A. Visconti, MD, Monmouth Beach; age 88
Eli A. Wallack, MD, Golden Shores, Florida; age 81
Anthony J. Watman, MD, Allentown, Pennsylvania; age 91
Alfred M. Zitani, Sr, MD, Fort Lee; age 90

Mercer County

Joseph D. Brenna, MD, Trenton; age 69
Helen E. Daniells, MD, Princeton; age 71
Josephine C. DeFrancesco, MD, Yardley,
Pennsylvania (formerly Trenton); age 66
John A. Flood, Jr, MD, Trenton; age 70
Howard L. Levenson, MD, Boca Raton, Florida
(formerly Lawrenceville); age 65
Antonio C. Martinez-Tapia, MD, Lambertville; age 70
Alfred J. Strauss, MD, Naples, Florida
(formerly Trenton); age 68
Edward J. Surowiec, MD, Trenton; age 66

Middlesex County

Severin T. Golojuch, MD, South River; age 65
Samuel H. Silverman, MD, Edison; age 66

Monmouth County

James A. Weldon, MD, Hazlet; age 69
Miles S. Winder, Jr, MD, Allenhurst; age 73

Morris County

Raymond C. Maronpot, MD, Bernardsville; age 66
John C. Stockman, MD, Mendham; age 66
Cornelius H. Sullivan, MD, Millington; age 66
Adolph R. Wichman, MD, Boonton; age 71

Ocean County

Charles Harris, MD, Island Heights; age 66
Gorman Jaffe, MD, Lakewood; age 70

Passaic County

Samuel Baum, MD, Passaic; age 68
Eugene Bradley, MD, Pompton Lakes; age 66
Richard S. Colfax, MD, Pompton Lakes; age 68
Saul M. Grandinetti, MD, Clifton; age 68
Robert H. Joelson, MD, Ridgewood; age 68
Leonard V. Strully, MD, Fair Lawn; age 75
Alexander J. Zito, MD, Glen Rock; age 59

Louis A. Zuckerman, MD, Hawthorne; age 69

Salem County

Harry W. Fullerton, Jr, MD, Carney's Point; age 69
Eugene T. Pashuck, MD, Woodstown; age 70

Union County

Charles Boozan, MD, Elizabeth; age 70
Gennaro F. Braga, MD, Elizabeth; age 69
Jacyntho A. DaSilva, MD, Newark; age 66
J. Campbell Howard, Jr, MD, Mountainside; age 67
Bong Hak Hyun, MD, Watchung; age 67
George F. Lane, MD, Plainfield; age 68
Theodore Loizeaux, MD, Plainfield; age 70
Warren B. Nestler, MD, Summit; age 68
James W. Robinson, MD, Westfield; age 69
Robert E. Rowand, MD, Summit; age 68
Irvin H. Sokolic, MD, Elizabeth; age 65
Herbert L. Weininger, MD, Mountainside; age 65

The Reference Committee recommended that the nominations be approved.
HOUSE ACTION: Adopted. The nominations were approved.

Supplemental Report #1

Nominations for Emeritus Membership

(Reference Committee "B")

The following additional nominations for election to emeritus membership of the Medical Society of New Jersey have been received:

Cumberland County

Costabile Cilento, MD, Avalon; age 66

Middlesex County

Harold Cano, MD, Spotswood; age 68
Wellington Hsia, MD, Scotch Plains; age 67
Murray Wagman, MD, Metuchen; age 72

Morris County

Leo Lewin, MD, Mount Arlington; age 68

The Reference Committee recommended that the nominations be approved.
HOUSE ACTION: Adopted. The nominations were approved.

Supplemental Report #2

Nominations for Emeritus Membership

(Reference Committee "B")

The following additional nominations for election to emeritus membership of the Medical Society of New Jersey have been received:

Bergen County

Ralph M. Talucci, MD, Midland Park; age 64
Gisela H. Ucko, MD, Glen Rock; age 68

Camden County

Oram R. Kline, Jr, MD, Camden; age 68

Ocean County

Gorman Jaffe, MD, Lakewood; age 70
Hugh McCulloch, Jr, MD, Bay Head; age 69

Passaic County

Thomas F. Reilly, MD, Jamesburg; age 79
David Roth, MD, Glen Rock; age 65
Harold J. Sargent, MD, Newfoundland; age 67

The Reference Committee recommended that the nominations be approved.

HOUSE ACTION: Adopted. The nominations were approved.

Supplemental Report #3

Nominations for Emeritus Membership

(Reference Committee "B")

The following additional nomination for election to emeritus membership of the Medical Society of New Jersey has been received:

Middlesex County

Bernard B. Boodin, MD, Fords; age 61

The Reference Committee recommended that the nomination be approved.

HOUSE ACTION: Adopted. The nomination was approved.

Resolution #2

Introduced by: Essex County Medical Society
Subject: Summary of Convention Issues and Resolutions
Referred to: Reference Committee "B"

Whereas, current policy is that MSNJ delegates receive a comprehensive packet of House of Delegates activities in April and alternate delegates do not; and

Whereas, both groups could use a brief, advance summary of all important convention resolutions, problems, and discussions under consideration which call for votes of the House; and

Whereas, the AMA, in *AM News*, issues a succinct summary prior to the convention, giving one short paragraph on each resolution and problem (usually one sentence), and naming which reference committee will consider it; and

Whereas, this is of value in involving physicians in important activities and to assure they do not miss one which might interest them; and

Whereas, the capsulated advance convention news will assist them in making a decision as to which reference committee to attend; and

Whereas, this would create more advance interest of delegates and alternates in attending all sessions; now therefore be it

Resolved, that the Medical Society of New Jersey issue all delegates and alternates and county societies a one paragraph, succinct summary of each resolution and problem to come before the House, well in advance of the convention, noting the assigned reference committee.

The Reference Committee recommended that Resolution #2 be rejected.

HOUSE ACTION: Adopted. Resolution #2 was rejected.

Resolution #4

Introduced by: Essex County Medical Society
Subject: Tanning Salon Legislation
Referred to: Reference Committee "B"

Whereas, social acceptance of "a tan" and belief it is a healthy condition led to 17,000 tanning salons and public health problems; and

Whereas, physician complaints about the potential harmful changes of high intensity UVA exposure have encompassed cataracts, skin cancer, impairment of the immune system, premature aging of skin, and photosensitivity reactions when using perfume, cosmetics, and certain drugs, including some antibiotics and birth control pills; and

Whereas, the AMA called for public education on this topic and believes appropriate tanning salon requirements should be established; and

Whereas, a new California law requires tanning salons to inform customers of risks of overexposure, the necessity to protect the eyes, and the danger of taking certain medications while tanning, along with imposing parental consent requirements for those under 18 years of age; now therefore be it

~~Resolved, that the Medical Society of New Jersey study what safety precautions are needed regarding tanning salons in New Jersey and determine whether or not seeking legislation similar to California law is appropriate and advisable.~~

Resolved, that the Medical Society of New Jersey work with the New Jersey Department of Health, the Dermatological Society of New Jersey, and other appropriate agencies to determine what safety precautions are needed regarding tanning salons in New Jersey, and whether or not legislation similar to California law is advisable.

The Reference Committee recommended that Resolution #4 be adopted as amended.
HOUSE ACTION: *Adopted as amended by the Reference Committee.*

Resolution #5

Introduced by: Essex County Medical Society
Subject: Change Polluting Habits
Referred to: Reference Committee "B"

Whereas, since 1977, the Medical Society of New Jersey has led the fight against toxic chemical waste polluters, sludge, and chemical and plastic polluters; and

Whereas, MSNJ has called for laws and their enforcement against every major polluter, from shore sludge dumping towns to inshore garbage disposal operations, and even against the city of New York; and

Whereas, there are small-time polluters, such as you and I who must think about what they are doing and revise their habits; and

Whereas, millions of small-time polluters add up to big polluting problems; and

Whereas, boaters, fishermen, and recreational swimmers are concerned about preserving our beaches and natural resources; and

Whereas, we are facing more contamination and public health problems which are being aggravated by citizens unthinkingly adding to the unneeded waste; now therefore be it

Resolved, that the Medical Society of New Jersey sponsor television public service announcements, and small spots on radio and television, and news releases to educate the public on proper waste disposal habits.

The Reference Committee recommended that Resolution #5 be referred to the Board of Trustees for appropriate action.

HOUSE ACTION: *Adopted. Resolution #5 was referred to the Board of Trustees for appropriate action.*

Resolution #8

Introduced by: Bergen County Medical Society
Subject: Nonpayment of Mandatory Assessment for Patient Education
Referred to: Reference Committee "B"

Whereas, at the 1987 Annual Meeting of the Medical Society of New Jersey, House of Delegates, Resolution #24, "Mandatory Assessment for Patient Education" was adopted; and

Whereas, the first resolved of that resolution states "that mandatory assessment of \$100 for one year to additionally fund the activities of the Council on Public Relations"; and

Whereas, approximately 800 members of the Medical Society of New Jersey have neglected to pay this assessment; and

Whereas, the Bylaws of the Medical Society of New Jersey (Chapter X, Section 5) clearly state "... delinquency in regard to a special assessment shall be treated in the same fashion as delinquency in the annual assessment."; and

Whereas, the Bylaws of the Medical Society of New Jersey (Chapter X, Section 1 [c]) specifically state "If a member has not paid his annual assessment by June first, his name shall be dropped from the membership rolls."; now therefore be it

~~Resolved, that the officers of the Medical Society of New Jersey should take steps to make delinquents pay the \$100 assessment within 90 days of adoption of this Resolution and those not paying the assessment should be dropped from the MSNJ membership; and be it further~~

~~Resolved, that if the officers of MSNJ do not take this action, they should be impeached on the grounds of dereliction of duty in accordance with the MSNJ Bylaws.~~

There was considerable discussion concerning reminders mailed on a regular basis to delinquent members resulting in a number of payments. Those failing to remit were deleted from the current *Membership Directory*. Legal counsel was requested to comment on this Resolution. He advised that the actions taken by the Board of Trustees were legal, reasonable, and consistent with the Bylaws and overall, reflect a fiscally prudent policy. The Reference Committee agreed.

The Reference Committee recommended that Resolution #8 be rejected.

HOUSE ACTION: *The recommendation of the Reference Committee was not adopted. Substitute Resolution #8 was adopted.*

Substitute Resolution #8

Nonpayment of Mandatory Assessment for Patient Education

Resolved, that the names of all those physicians who have not paid the special assessment be published in *NEW JERSEY MEDICINE*.

Resolution #15

Introduced by: Ocean County Medical Society
Subject: Medical Waste Disposal
Referred to: Reference Committee "B"

Whereas, contamination of our shores has heightened concern for the effective disposal of medical waste; and

Whereas, this concern has resulted in the Ocean County Medical Society investigating and subsequently endorsing a disposal company; and

Whereas, a disposal company has offered to provide service to members of the Ocean County Medical Society at a discounted rate; and

Whereas, medicine's concern for well-controlled medical waste disposal would generate a positive public image; now therefore be it

Resolved, that the Medical Society of New Jersey investigate and endorse a medical waste disposal company and, if deemed possible by the Board of Trustees, endeavor to obtain their services at a discount to its membership.

The Reference Committee agreed that conflicting county and state regulations preclude the implementation of the action called for in Resolution #15.

The Reference Committee recommended that Resolution #15 be rejected.

HOUSE ACTION: The recommendation of the Reference Committee was not adopted. Resolution #15 was referred to the Board of Trustees.

Resolution #20

Introduced by: John Winslow, MD, Delegate, Essex County
Subject: Mobile Intensive Care Unit (MICU) Squads
Referred to: Reference Committee "B"

Whereas, the concept of mobile intensive care units (MICUs) out in the field long has been the darling of the medical schools and special teaching facilities; and

Whereas, rarely do the regular volunteer ambulance units go out without the MICU trailing close behind; and

Whereas, responsibility for rapid transport and care has been shifted from the volunteer squads to these MICUs, lowering the esprit of the regular groups; and

Whereas, the MICU squads never just can see that a patient is transported to the hospital without a long siege outside the pickup home or point, with starting of IV solutions, running electrocardiograms, and waiting for center/hospital interpretations, and the like, and the cost runs \$300 or so per trip to the patient or insurer; and

Whereas, police dispatchers seem afraid not to call the MICUs even though the attending physician calling the regular ambulance asks that the MICU not be involved, so that much time is lost in getting the patient to the hospital (such as with a ruptured aorta or gastrointestinal bleeding) while the MICU services are performed, all of which could have been done more expeditiously and completely at the hospital; and

Whereas, while some lives may have been saved, there is no accounting for those that may have lost the chance to survive because of the inordinate time delay, where evaluation of aortic rupture could have been made, or TPA treatment started when it might have helped; and

Whereas, there frequently is a difficult attitude on the part of the MICU squad members in their dealings with the private physicians, the emergency rooms, and the public in general; and

Whereas, the question of cost effectiveness has not been considered; now therefore be it

~~Resolved, that a thorough study and evaluation of the true value of the mobile intensive care unit squads so prevalent throughout the state be made by the Medical Society of New Jersey, with a careful look at the many "cons" concerning them, as well as the "pros"; and be it further~~

~~Resolved, that rules for greater cooperation with attending physicians be made, and the routine sending of these MICU squads, particularly when the attending requests that they not be sent, should be discontinued.~~

The Reference Committee recommended that the first resolved be deleted.

The Reference Committee recommended that the second resolved be amended as follows:

Resolved, that the Medical Society of New Jersey support the formation of guidelines for greater cooperation between attending physicians and MICU squads; and the evaluation on a local basis of the existing guidelines concerning the dispatching of MICU squads.

The Reference Committee recommended that Resolution #20 be adopted as amended.

HOUSE ACTION: The recommendation of the Reference Committee was not adopted. Substitute Resolution #20 was adopted by the House.

Substitute Resolution #20 Mobile Intensive Care Unit (MICU) Squads

Resolved, that the Medical Society of New Jersey Board of Trustees direct the Committee on Emergency Medical Care to investigate the current effectiveness and relationship among attending physicians, hospitals, and all emergency caregivers in the field, and to make recommendations through the Board of Trustees to appropriate state agencies concerning their findings.

Council on Medical Services

JOSEPH W. FLEISHER, MD, CHAIRMAN

(Reference Committee "C")

1. Committee on Occupational Health, Workers' Compensation, and Rehabilitation.

The Board of Trustees, at its meeting on April 10, 1988, discontinued the Committee on Occupational Health, Workers' Compensation, and Rehabilitation, its activities to be assumed by the Council on Medical Services.

2. Ad Hoc Committee on Health Care Reimbursement Policies. The Board of Trustees, at its meeting on April 1, 1988, disbanded the Ad Hoc Committee on Health Care Reimbursement Policies, its responsibilities to be assumed by the Council on Medical Services.

3. Medicare Program for New Jersey. Pennsylvania Blue Shield is the new fiscal intermediary for the Part "B" Medicare program for New Jersey beginning January 1, 1989. The Council has established contact with their people in an effort to assist the Society's membership in problems involving Part "B" of Medicare.

4. Resource-Based Relative Value Scale. The Board of Trustees referred the Harvard resource-based relative value study (RBRVS) to the Council on Medical Services for review. The Report AA of the AMA Board of Trustees, adopted by the AMA House of Delegates on December 6, 1988, was distributed to the Council. The Council agreed that this report is a valuable document requiring careful review before recommendations can be made. Therefore, complete consideration of the report was postponed until the next Council meeting.

5. Resolution #13—Disability Benefit Forms. The 1987 Resolution #13, Disability Benefit Forms, was referred to the Council on Medical Services for further study and development of appropriate methodology. This matter is under consideration by the Council and a report will be forwarded to the Board of Trustees when completed.

The Reference Committee recommended that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

Resolution #1

Introduced by: **Essex County Medical Society**
Subject: **PRO Denial**
Referred to: **Reference Committee "C"**

Whereas, there are many denials by the Peer Review Organization to hospital inpatients who are awaiting placement in long-term care facilities; and

Whereas, this directive has come down from the Consolidated Omnibus Reconciliation Act (COBRA), despite the requirement that social factors must be considered in admission and continued stay of patients who have a social need rather than a strict medical necessity for treatment; and

Whereas, HCFA has not implemented this COBRA provision and is interpreting it as applicable to rural settings only; now therefore be it

Resolved, that the Medical Society of New Jersey petition the Health Care Financing Administration to stop denials in instances where continued stay for admissions is based appropriately on social need; and be it further

Resolved, that cases of appropriate social necessity be reimbursable ~~to the hospital~~, and be it further

Resolved, that MSNJ instruct its delegates to the AMA to introduce a similar resolution at the next annual meeting of the AMA for implementation at the national level.

Resolved, that a copy of this Resolution be forwarded to the New Jersey Hospital Association for its information.

The Reference Committee recommended that the words "to the hospital," of the second resolved be deleted.

HOUSE ACTION: Adopted. The words "to the hospital" were deleted.

The Reference Committee recommended the addition of the fourth resolved.

HOUSE ACTION: Adopted. The fourth resolved was added.

The Reference Committee recommended that Resolution #1 be adopted as amended.

HOUSE ACTION: Adopted. Resolution #1 was adopted as amended by the Reference Committee.

Resolution #3

Introduced by: Essex County Medical Society
Subject: PRO/New Jersey Task Force
Referred to: Reference Committee "C"

Whereas, HCFA specifications for PRO contracts contain harsh sanctions for physicians; and

Whereas, PROs in some states have stricter than required contract provisions and charged physicians with fines up to \$35,000, as well as dismissed some physicians from the Medicare program; and

Whereas, PROs report unfavorable reviews to licensure boards; and

Whereas, the Washington State Medical Association implemented a special PRO task force to look into substantial sanctions and see that the physician was provided with due process and a fair hearing; and

Whereas, many Washington state sanctions were dismissed or reduced because of the activities of this task force; now therefore be it

Resolved, that the Medical Society of New Jersey establish a "PRO New Jersey Task Force," similar to the one established by the Washington State Medical Association, in order to see that MSNJ members receive due process and fair treatment in PRO sanction hearings.

The Reference Committee recommended that Resolution #3 be referred to the Board of Trustees for appropriate action.

HOUSE ACTION: Adopted. Resolution #3 was referred to the Board of Trustees for appropriate action.

Resolution #6

Introduced by: Bergen County Medical Society
Subject: No Compromise on Malpractice Surcharge
Referred to: Reference Committee "C"

Whereas, the special deputy commissioner of insurance in her report to the commissioner recommended that New Jersey physicians who were insured by the New Jersey Medical Malpractice Reinsurance Association be required to pay a 5 percent surcharge on their malpractice premiums for the next seven years; and

Whereas, those physicians who were insured by other entities would be required to pay a 2.5 percent surcharge on malpractice premiums to wipe out the multimillion dollar deficit left by the defunct Reinsurance Association; and

Whereas, it is the position of the Medical Society of New Jersey that this proposed action by the commissioner is not a full, fair, or completely legal treatment of the problem; now therefore be it

Resolved, that the Medical Society of New Jersey immediately inform the commissioner of insurance that it is uncompromising in its firm stand that a malpractice surcharge of any amount to physicians is unconscionable; and be it further

Resolved, that not only may there be no compromise but the Medical Society of New Jersey will not accept any surcharge imposed on physicians and that, if necessary, will go to court to prevent the New Jersey Department of Insurance from levying this surcharge.

The Reference Committee considered Resolutions #6 and #7 jointly because of the similarity of the subject matter.

It was noted that the Board of Trustees has retained the services of special counsel, Judge Herbert J. Stern, to represent the Society on this issue. Judge Stern has been invited to address the House of Delegates at the final session.

Since the Society's position must depend upon what is legally acceptable, the Board of Trustees will need the ability to follow Judge Stern's advice.

The Reference Committee recommended that Resolutions #6 and #7 be rejected.

HOUSE ACTION: *The recommendation of the Reference Committee was not adopted. Resolutions #6 and #7 were referred to the Board of Trustees.*

Resolution #7

Introduced by: Bergen County Medical Society
Subject: No Malpractice Surcharge for Any Physician in New Jersey
Referred to: Reference Committee "C"

Whereas, the deficit incurred by the New Jersey Medical Malpractice Reinsurance Association program has been demonstrated to be caused by mismanagement of the insurance commissioner; and

Whereas, those physicians enrolled in the New Jersey Medical Malpractice Reinsurance Association program were victims of this incompetent mismanagement; now therefore be it

Resolved, that the Medical Society of New Jersey represent all member physicians and fight to prevent any surcharge on any physicians in this state; and be it further

Resolved, that the Medical Society of New Jersey inform its membership of this change.

HOUSE ACTION: *See Resolution #6.*

Resolution #12

Introduced by: Monmouth County Medical Society
Subject: Unfair Medicare Reimbursement
Referred to: Reference Committee "C"

Whereas, physicians in the state of New Jersey traditionally have been separately reimbursed by the Medicare Part B fiscal intermediary for procedures and for evaluations and medical care prior and after procedures; and

Whereas, Pennsylvania Blue Shield, as the new fiscal intermediary for Medicare Part B, has instituted a policy of paying for above services via a global fee; and

Whereas, the methodology that Pennsylvania Blue Shield is using to establish the rate for the global fee is based only upon the reimbursement rate for the procedure itself, which administratively decreases physician reimbursement by the sum of all pre- and post-procedure care; and

Whereas, a more equitable method of establishing a global fee would be combining the sums of the MAACs for pre- and post-procedure care with the MAAC for the procedure itself, thus establishing a new global MAAC; now therefore be it

Resolved, that the Medical Society of New Jersey enter into negotiations with Pennsylvania Blue Shield, as fiscal intermediary for Medicare Part B, for the purpose of establishing fair and equitable profiles and MAAC schedules based on a global fee system; and be it further

Resolved, that, should negotiations fail to establish fair and equitable global fee reimbursement levels, the Medical Society of New Jersey pursue, through all legal means available, the establishment of fair and equitable global rates.

The Reference Committee combined consideration of Resolutions #12, #25, #26, #30, and #32 because of their similarity.

After hearing testimony presented before the Reference Committee, the sponsors of the Resolutions felt that the issues addressed had been resolved through negotiations with Pennsylvania Blue Shield. The sponsors requested that the Resolutions be withdrawn.

The Reference Committee recommended that the sponsors be granted leave to withdraw Resolution #12.

HOUSE ACTION: Resolution #12 was withdrawn.

Resolution #16

Introduced by: Hospital Medical Staff Section
Subject: Clear, Concise, and Complete Explanation of Benefits
By All Third-Party Payors
Referred to: Reference Committee "C"

Resolved, that the Medical Society of New Jersey seek legislation which requires all third-party payors to explain to their beneficiaries, in clear and simple terms, those medical services and procedures which they (third-party payors) will and will not cover; and be it further

Resolved, ~~that there be legislation that requires all third-party payors to provide an easily understandable indemnity payment schedule to their beneficiaries; and be it further~~ *that the Medical Society of New Jersey seek legislation that requires all third-party payors to provide an easily understandable indemnity payment schedule to their beneficiaries; and be it further*

Resolved, that the Medical Society of New Jersey vigorously resist any attempt to directly, indirectly, or surreptitiously shift the responsibility for explanation of policy benefits to physicians.

The Reference Committee recommended the first line of the second resolved be amended (italics indicate amendment).

The Reference Committee recommended that Resolution #16 be adopted as amended.

HOUSE ACTION: Adopted. Resolution #16 was adopted as amended by the Reference Committee.

Resolution #17

Introduced by: Frank J. Primich, MD, Delegate, Hudson County
Subject: Inadvisability of Medicare "Participation"
Referred to: Reference Committee "C"

Whereas, organized medicine's resistance to the Medicare program was overcome initially by the since-broken promise of noninterference and free choice; and

Whereas, voluntary acceptance of assignment already occurs in a high percentage of cases; and

Whereas, universal acceptance of assignment would represent socialized medicine for all seniors, including the wealthy; and

Whereas, "participants" are rewarded with a paltry relative increase in fees of 1 percent, while punitive actions are proposed for the "nonparticipants"; and

Whereas, these coercive methods of discrimination, if allowed to continue, will set the stage for enforced servitude of the entire medical profession; and

Whereas, compromise and conciliation have accomplished little in deterring this ongoing process; and

Whereas, there are ample legal, moral, and ethical grounds upon which to resist this intrusion; now therefore be it

Resolved, that the Medical Society of New Jersey urge the AMA to declare that Medicare "participation" status neither is in the best interest of its members, nor that of their patients; and be it further

Resolved, that the Medical Society of New Jersey urge the AMA to oppose discriminatory policies regarding Medicare "nonparticipants" being used by the federal government; and be it further

Resolved, that copies of Resolution #17 be distributed to all state medical societies for their information.

The Reference Committee recommended that the word "Medicare" be inserted before the word "nonparticipants" in the second resolved.

HOUSE ACTION: Adopted. The word "Medicare" was inserted in the second resolved (italics indicate amendment).

The Reference Committee recommended the addition of a third resolved.

HOUSE ACTION: Adopted. The third resolved was added.

The Reference Committee recommended that Resolution #17 be adopted as amended.

HOUSE ACTION: Adopted. Resolution #17 was adopted as amended by the Reference Committee.

Resolution #18

Introduced by: John Winslow, MD, Delegate, Essex County
Subject: Overutilization of Cardiac Pacemaker Testing
Referred to: Reference Committee "C"

Whereas, permanent cardiac pacemakers, for most patients, have a life-enhancing rather than life-saving effect, with malfunction or battery failure being problems but not ones for dire concern; and

Whereas, over the last decade pacemakers have undergone many electronic refinements so that a six-year guarantee has become standard, with malfunction and failure a rarity; and

Whereas, from the early days of pacemakers there is a holdover ethic in the following pattern:

The physician (referral surgeon or cardiologist) who inserts the device has the patient come to his office or hospital base for routine electronic pacemaker testing on a frequent basis, such as four times a year, starting immediately after the instrument's placement; and

The primary physician/cardiologist gets a report letter, often including a graphic picture of waves and times, saying that the pacemaker is functioning well and that the patient is asked to come back in another three months, etc., or to continue the telephone modem testing, and regards, etc., and

Whereas, pacemakers can begin to function abnormally without any particular warning, in spite of testing, and the patient usually becomes aware of malfunction, and a simple check by the patient's primary physician can pick it up, with a plain electrocardiogram; and

Whereas, a major negative effect of the multiple routine checks by the pacemaker-inserting physician is the all-too-frequent failure of the patient to realize that more thorough medical care followup is necessary, even though he/she knows that the visit to the inserting physician consists mostly of checking the pacemaker function; and

Whereas, poor quality care may result with multiple medical problems being picked up late or missed with the primary physician no longer felt to be a necessary part of the health team, since the perception by the patient remains that no other medical care is needed; now therefore be it

Resolved, that the Medical Society of New Jersey adopt the following policy:

1) Frequent routine electronic testing of permanent pacemakers no longer should be the accepted standard for good followup care. Medicare and other insurance carriers should not be expected to cover it, except at yearly intervals or under special circumstances which would have to be documented.

2) Any special testing to be done, such as yearly, should be authorized by the primary attending physician at whatever testing site that physician would wish to choose.

Following considerable discussion at the hearing, the sponsor requested that the Resolution be withdrawn.

The Reference Committee recommended that the sponsor of Resolution #18 be granted leave to withdraw the Resolution.

HOUSE ACTION: Resolution #18 was withdrawn.

Resolution #23

Introduced by: Passaic County Medical Society
Subject: Assisting Surgeons and Medicare Reimbursement
Referred to: Reference Committee "C"

Whereas, good surgical practice requires a duly qualified assisting surgeon for major surgical procedures; and

Whereas, surgeons in New Jersey traditionally have used licensed physicians and/or duly qualified surgical residents in approved training programs as assistants for major surgical procedures; and

Whereas, the State Board of Medical Examiners mandates the use of a qualified assistant in all surgical procedures in which an opening is made into any three of the major body cavities: abdomen, chest, or head; and

Whereas, the assisting surgeon in such procedures had been reimbursed by Medicare while Prudential served as the intermediary; and

Whereas, Pennsylvania Blue Shield, the new Medicare intermediary, is not reimbursing assisting surgeons in such procedures; now therefore be it

Resolved, that the Medical Society of New Jersey ~~shall~~ *continue to* vigorously protest the failure of Pennsylvania Blue Shield to pay for a surgical assistant for all procedures which involve entry into the major body cavities and demand Medicare reimbursement for assistants in such procedures since current state law requires the presence and participation of an assisting surgeon in those instances.

The Reference Committee recommended that the word "shall" be deleted and the words "continue to" be substituted in the resolved (*italics indicate amendment*).

HOUSE ACTION: *Adopted. The words "continue to" were substituted for "shall" in the resolved.*

The Reference Committee recommended that Resolution #23 be adopted as amended.

HOUSE ACTION: *Adopted. Resolution #23 was adopted as amended by the Reference Committee.*

Resolution #24

Introduced by: Michael I. Baruch, MD, Delegate, Passaic County
Subject: Physician Attestation for Medicare Reimbursement
Referred to: Reference Committee "C"

Whereas, Medicare requires that the physician sign an attestation at each individual hospital which states that any one who misrepresents, falsifies, or conceals essential information required for payment by federal funds may be subject to fines or imprisonment or civil penalty under applicable federal laws; and

Whereas, reimbursement is based solely on the inscribed codes for each case which are entered by a clerical coder who is employed by the hospital in its medical records department; now therefore be it

Resolved, that the Medical Society of New Jersey take appropriate action to assure that the hospital not only be responsible for proper coding, but also bear any liability for fines or penalties under federal law for both incorrect coding and improper coding which go beyond the information attested to by the physician.

The Reference Committee recommended that Resolution #24 be adopted.

HOUSE ACTION: *The recommendation of the Reference Committee was adopted.*

Resolution # 25

Introduced by: Passaic County Medical Society
Subject: Medicare Reimbursement and Preoperative Consultations
Referred to: Reference Committee "C"

Whereas, the Medicare payment schedule is based on physicians' fees in 1984; and
Whereas, in 1984 in New Jersey, the fees for a surgical procedure did not include a charge for preoperative consultation or treatment; and

Whereas, Medicare had reimbursed preoperative care prior to Pennsylvania Blue Shield becoming the intermediary, but no longer does so; now therefore be it

Resolved, that the Medical Society of New Jersey take action to restore separate payment, where appropriate, for preoperative consultations and treatment; and be it further

Resolved, that if Pennsylvania Blue Shield will not pay separately for preoperative consultation and treatment, the Medical Society of New Jersey will take action to have the payment schedule revised so that payment for a procedure will be based on the 1984 physician fees for the procedure plus an added amount for preoperative consultation and treatment based on the 1984 physicians' fees for preoperative consultations and treatments.

The Reference Committee combined consideration of Resolutions #12, #25, #26, #30, and #32 because of their similarity. See discussion under Resolution #12.

The Reference Committee recommended that the sponsors be granted leave to withdraw Resolution #25.

HOUSE ACTION: Resolution #25 was withdrawn.

Resolution # 26

Introduced by: The Urology Society of New Jersey
Subject: Medicare—Arbitrary and Capricious Denials
Referred to: Reference Committee "C"

Whereas, Medicare reimbursement via Pennsylvania Blue Shield has resulted in the arbitrary and capricious denial of payments, such as for consultations, histories, physicals, and necessary diagnostic procedures; and

Whereas, these problems affect a large number of physician members of the Medical Society of New Jersey; now therefore be it

Resolved, that the Medical Society of New Jersey give the highest priority to effecting the means of correcting these carrier abuses; and be it further

Resolved, that if the efforts of the Medical Society of New Jersey are not successful, a special session of the House of Delegates should be called in the fall of 1989 to determine further actions.

The Reference Committee combined consideration of Resolutions #12, #25, #26, #30, and #32 because of their similarity. See discussion under Resolution #12.

The Reference Committee recommended that the sponsors be granted leave to withdraw Resolution #26.

HOUSE ACTION: The recommendation was not adopted. Resolution #26 was referred to the Board of Trustees.

Resolution # 27

Introduced by: The Urology Society of New Jersey
Subject: Medicare Reimbursement—Urology
Referred to: Reference Committee "C"

Whereas, the Urology Society of New Jersey has found that there is no urologist associated with Pennsylvania Blue Shield with whom it can discuss specific urological policy complaints; now therefore be it

~~Resolved, that the Medical Society of New Jersey request Pennsylvania Blue Shield to appoint a specific practicing urologist as a liaison regarding specific policy problems, including reimbursement problems within urology; and be it further~~

~~Resolved, that Pennsylvania Blue Shield be requested to make similar appointments for each medical specialty; and be it further~~

~~Resolved, that Pennsylvania Blue Shield publish the list of these appointees.~~

The Reference Committee was advised that Pennsylvania Blue Shield has a consultant in urology on staff and similar appointments are planned for other specialty groups. It is not the policy of Pennsylvania Blue Shield to publish the names of the appointees; public disclosure is left to the discretion of the individual consultants. It was noted that the same policy was followed by Prudential, the former Medicare carrier.

The Reference Committee recommended that Resolution #27 be rejected.

HOUSE ACTION: The recommendation was not adopted. Substitute Resolution #27 was adopted.

Substitute Resolution #27 Medicare Reimbursement

Resolved, that, if a physician requests review by a peer of his or her specialty of a complaint, problem, or issue, Pennsylvania Blue Shield should insure that such a practicing specialist (board certified or equal qualification) has reviewed the issue and, further, that the requesting physician be assured, in writing, that this review has occurred.

Resolution # 29

Introduced by: Hudson County Medical Society
Subject: Assignment of Laboratory Tests
Referred to: Reference Committee "C"

Whereas, many patients prefer the convenience and timeliness of laboratory tests performed in the physician's office; and

Whereas, patients receiving chemotherapy, or tests for diabetes or hemorrhage, often need instant results; and

Whereas, patients severely debilitated often find it impossible to go to independent laboratories for their tests; and

Whereas, patients with both Medicare and the extra coverage of major medical are precluded from reimbursement for tests requested on an unassigned basis in the physician's office; and

Whereas, Medicare is creating a "second class" of patient who must wait days for results while full-pay private patients often have their laboratory results before they leave the physician's office; and

Whereas, reimbursement to patients for tests performed on an unassigned basis in the physician's office will not cost Medicare any more money than reimbursement made directly to the physician; now therefore be it

~~**Resolved**, that the Medical Society of New Jersey inform the United States Congress of its great displeasure concerning assignment of office laboratory testing; and be it further~~

Resolved, that the Medical Society of New Jersey inform the United States Congress of the inconvenience and medical risk forced on patients by current laws with regard to office laboratory testing.

Resolved, that the Medical Society of New Jersey urge Congress to permit patients to be reimbursed for, and physicians to perform, tests in their offices on an unassigned basis.

The Reference Committee recommended that the first resolved be amended.

The Reference Committee recommended that Resolution #29 be adopted as amended.

HOUSE ACTION: Adopted. Resolution #29 was adopted as amended by the Reference Committee.

Resolution # 30

Introduced by: Hudson County Medical Society
Subject: Medicare Global Fees
Referred to: Reference Committee "C"

Whereas, Pennsylvania Blue Shield has assured the Medical Society of New Jersey of no major changes during the transition period in payment policy; and

Whereas, since January 1, 1989, providers who perform consults and procedures on patients on the same day are invariably denied reimbursement for consultation; and

Whereas, history, physical, and chart reviews are medically necessary prior to performing many procedures; and

Whereas, MAACs were calculated for consults and procedures; and

Whereas, Pennsylvania Blue Shield has "lumped" reimbursement for both consult and procedure; now therefore be it

Resolved, that the Medical Society of New Jersey urge Pennsylvania Blue Shield to reimburse for medically necessary consult on day of procedure or recalculate the MAAC to cover both the cost of consult and procedure.

The Reference Committee combined consideration of Resolutions #12, #25, #26, #30, and #32 because of their similarity. See discussion under Resolution #12.

The Reference Committee recommended that the sponsors be granted leave to withdraw Resolution #30.

HOUSE ACTION: Resolution #30 was withdrawn.

Resolution #32

Introduced by: Union County Medical Society
Subject: Medicare Global Fees
Referred to: Reference Committee "C"

Whereas, Medicare provides that payment for medical services must be "reasonable" and "necessary"; and

Whereas, between 1966 and 1988, Medicare payments in New Jersey have been made on the basis of each separate service provided to the patient; and

Whereas, since January 1989, physicians have performed medical services such as consultations and diagnostic procedures which are reasonable and necessary, but there has been no payment for many of these services, which were previously paid by Medicare; and

Whereas, such denial of payment is arbitrary and capricious; and

Whereas, such unfair lack of payment is destructive to the physician-patient relationship; now therefore be it

Resolved, that Medical Society of New Jersey policy be in strong opposition to changes in reimbursement policies such as global fees which have led to denial of physicians' historical compensation for medically necessary services and procedures.

The Reference Committee combined consideration of Resolutions #12, #25, #26, #30, and #32 because of their similarity. See discussion under Resolution #12.

The Reference Committee recommended that the sponsors be granted leave to withdraw Resolution #32.

HOUSE ACTION: *The speaker ruled that Resolution #32 was unclear and, therefore, was not considered by the House of Delegates.*

Resolution #33E

Introduced by: Union County Medical Society
Subject: Removal of Discriminatory and/or Biased Provisions Toward Nonparticipating Physicians
Referred to: Reference Committee "C"

Whereas, the subheading for Section 1801, Title XVIII Health Insurance for the Aged and Disabled (Medicare) states, "prohibition against any federal interference"; and

Whereas, the subheading for Section 1802 of the Medicare law states "free choice of patient guarantee"; and

Whereas, subsequent directives have subverted these promises to the American people; and

Whereas, a recent HCFA explanation of benefits contains the following: "You are responsible for a total of \$XX, the difference between the billed amount and the Medicare payment. You could have avoided paying \$XX; the difference between the billed and approved amount, if the claim had been assigned. If you have other insurance, it may help with the part Medicare did not pay."; now therefore be it

Resolved, that the Medical Society of New Jersey request the AMA to immediately and vigorously petition Congress, HCFA, and Part B carriers, with regard to Medicare, to remove discriminatory and/or biased provisions toward nonparticipating physicians; and be it further

Resolved, that the Medical Society of New Jersey ask the AMA to immediately and vigorously petition Congress, HCFA, and the Part B carriers to ensure that explanation of Medicare benefits states nothing more than the reimbursement for medical services and procedures.

The Reference Committee recommended that Resolution #33E be adopted.

HOUSE ACTION: *Adopted.*

Resolution # 34E

Introduced by: Ocean County Medical Society
Subject: Medical Society of New Jersey Peer Review Organization Foundation
for Practicing Members
Referred to: Reference Committee "C"

Whereas, radical changes have been made in recent years and continue to be made affecting the delivery of health care in the United States; and

Whereas, the United States Congress in its legislative authority has radically changed the manner in which health care is delivered and reimbursed to physicians in the Medicare program; and

Whereas, third-party payors have followed the coattails of government in following similar action, including the utilization of managed care to reduce costs of health care; and

Whereas, physicians have been functioning in disarray in an effort to comprehend and to adjust to these changes in the delivery of health care which is impacting the delivery of quality of care; and

Whereas, peer review activities have been monitoring the care rendered by physicians through the utilization of nonphysician reviewers, criteria, guidelines, and the administration of "points"; and

Whereas, patients are being denied appropriate care that is rendered prospectively after retrospective review after the outcome is known; and

Whereas, there is a need for a uniform and unified approach in dealing with the many issues that are being raised on a daily basis including the recent efforts by Congress to deny medically unnecessary or medically unreasonable treatment; and

Whereas, the established legal plan of MSNJ does not address the many global issues involved by physicians in peer review actions; and

Whereas, the quality of care impacts medical liability and patient care; now therefore be it

Resolved, that the Medical Society of New Jersey establish a peer review foundation for the benefit of its members to deal with any issue involved in the delivery of health care by its members in order to ensure due process is given as well as support in any action that may be deemed defensible; and be it further

Resolved, that this foundation address directives from third-party payors that may adversely impact access and the delivery of health care; and be it further

Resolved, that the foundation be funded through dues assessment from those physicians who desire to become members.

Resolution #34E was not accepted as an emergency resolution.

Resolution # 35E

Introduced by: Ocean County Medical Society
Subject: Negotiating with Medicare
Referred to: Reference Committee "C"

Whereas, decisions made by the administrators of Medicare have a far-reaching impact on providers; and

Whereas, no mechanism exists for appeal of unilateral decisions, nor for arbitration of fee disputes between Medicare and providers; now therefore be it

Resolved, that the AMA delegation request that the AMA lobby the administration to set up an arbitration mechanism between the Health Care Financing Administration and the AMA.

The Reference Committee noted that the resolved did not reflect the intent of the whereases. Therefore, it was felt that this issue is unclear; and noted that there is a mechanism currently in place to deal with fee disputes. Since fee disputes involve local fiscal intermediaries and state societies, the Reference Committee felt it would be best dealt with on a local level rather than at the national level.

The Reference Committee recommended that Resolution #35E be rejected.

HOUSE ACTION: *The recommendation was not adopted. Resolution #35E was referred to the Board of Trustees.*

Resolution # 36E

Introduced by: Patricia G. Klein, MD, Delegate, Bergen County
Subject: ICD-9-CM Coding Regulations
Referred to: Reference Committee "C"

Whereas, HCFA has mandated that all physicians use ICD-9-CM diagnosis codes for all visits and procedures; and

Whereas, this puts a significant burden on an already overburdened physician's office staff to learn and use the proper codes, especially for primary care physicians; and

Whereas, the patient will not be reimbursed on unassigned claims submitted without a code; and

Whereas, insufficient time has been given to phase in this program; now therefore be it

Resolved, that the Medical Society of New Jersey strongly request that HCFA ~~defer~~ rescind implementation of the ICD-9-CM coding regulations.

The Reference Committee recommended that the word, "defer" be deleted and the word "rescind" be substituted in the resolved.

HOUSE ACTION: *Adopted. The word "rescind" was substituted for "defer."*

The Reference Committee recommended that Resolution #36E be adopted as amended.

HOUSE ACTION: *Adopted. Resolution #36E was adopted as amended by the Reference Committee (italics indicate amendment).*

Council on Public Relations

JOSEPH N. MICALE, MD, CHAIRMAN

(Reference Committee "D")

The Council on Public Relations studied a number of projects in conjunction with the mandates and suggestions offered by the House of Delegates, the Board of Trustees, the general membership, and individual contributions made by members of the Council on Public Relations, as well as legislative PR campaign contributions from Katz Martin Brill & Company.

1. Resolutions and Recommendations—1988, from the House of Delegates, Board of Trustees, Council on Public Relations, Membership, and Executive Director of the Medical Society of New Jersey.

A. A specific mandate from the House of Delegates was a recommendation to continue to promote the senior citizen programs adopted by the 1987 House of Delegates (Resolution #27).

B. There was a referral by the Board of Trustees, at the request of the Council on Mental Health, that was considered at the September 28, 1988, meeting. It was a request that three 30-second public service video messages on teen suicide, depression, and panic anxiety disorder, supported by a telephone referral service, be coordinated with the New Jersey Psychiatric Association (NJPA). The Council on Public Relations agreed to incorporate these into its program provided the logistics of handling the telephone call-in messages from the public could be appropriately worked out by the Council on Mental Health NJPA.

C. Dr. Micale's request for county liaison representatives to be present at the Council on Public Relations meetings resulted in two counties (Camden and Middlesex) designating representatives.

D. The Council on Public Relations has tried to change the format of the Golden Merit Award on numerous occasions, to accommodate time constraints, traffic movement, and the reception to produce an event with the dignity and warmth this occasion merits. The Council is of the opinion the current format for the Golden Merit Award Ceremony should be continued at this time, as best serving those honored by this affair. The Council will continue to observe and improve on the format wherever possible.

E. The Council reviewed and discussed potential programming of MSNJ's public relations activities for the 1988 yearly schedule. The development and implementation of media releases followed the Council's review: high cost of medical care; senior citizen fall hazard survey in cooperation with hospitals and nursing homes; catastrophic health care Medicare program; proliferation of alternate health care delivery advisory warning; the sacrifice of quality health care to accommodate cost cutting; an appeal to the public to understand our concerns about bureaucratic fiat and controls that impact on the quality of health care and inviting the public to join us in a nonadversary role to work for our mutual benefit; and senior Americans with the release, "A Growing Force," was a sincere effort to demonstrate to the public that the membership of MSNJ recognizes the problems seniors have to contend with and points out services that can help them with health support systems that will enrich their lives. All of our efforts in public relations are directed to present a true and acceptable image of New Jersey physicians attempting to deliver quality health care to their patients under increasingly difficult conditions and inviting them to make their concerns known to their legislative representatives.

2. Public Relations Activities—Continuing Projects.

A. Publication and distribution of the Membership Newsletter as part of *NEW JERSEY MEDICINE*, the journal of the Medical Society of New Jersey.

B. Monthly public health/public relations releases in the media, primarily newspapers and magazines (*Time/Newsweek*), including: The High Cost of Health Care; Fall Prevention Hazard Warnings; Catastrophic Health Care; Health Care's Latest Editions; Health Care Cost Cutting; Let's Work Together; Medicare Changes; and MSNJ's Medicare Senior Citizen Program and Older America—A Growing Force.

The Fall Prevention Hazard Warning promotion was released in the newspapers and *Time/Newsweek*. It also was sent to 115 hospitals for use in their public marketing and PR activities, 21 county agencies on aging for their public service activities, the state of New Jersey

Division on Aging, all registered nursing homes in the state, and New Jersey insurance companies for inclusion in their marketing programs relating to patient care.

C. There were 15- to 30-second public service television releases on selected promotions developed from our media releases.

D. Preparation and distribution of special news releases and publicity as required in furtherance of the Society's interest and activities including: Annual Meeting, selected official programs and special activities, including professional liability newspaper releases explaining MSNJ's position on professional liability, DRGs, and MSNJ's Medicare-Senior Citizen Program.

E. Participation in development of cooperative interstate PR activities resulting from Massachusetts, New York, and Pennsylvania requesting assistance and permission to use MSNJ releases.

F. The Golden Merit Award Ceremony, at which MSNJ senior physicians who have held the degree of doctor of medicine for 50 years receive formal recognition from their peers for their devotion to their profession and the patients they have served faithfully.

G. Support of orientation programs for new members by component societies.

H. Development of programming for the opening or closing of a medical office, includes buyer and seller guides, business side of medical practice, legal time bombs, physician's responsibilities under New Jersey controlled dangerous substances act, retirement information, and counseling of estate closings (procedures, regulations, and responsibilities).

I. Development of human services and consumer resources information for support of public service PR releases and patient information requests.

J. Placement services in *NEW JERSEY MEDICINE*.

K. Participation in medical television programs of informational value to the public—Channel 9-13 (cable) plus commercial stations in New York and Philadelphia using doctors from our specialty societies as speakers, plus political action program support and participation in New Jersey Network TV AIDS outreach commitment.

L. Newspapers. This year MSNJ published multiple releases on health topics such as: The High Cost of Medical Care; Fall Prevention Hazard Warnings; Catastrophic Health Care; Alternate Health Care; Health Care Cost Cutting; Let's Work Together; and Older America—A Growing Force; and MSNJ Senior Citizen Medical Courtesy Program. These informative releases strongly demonstrate physician care and concern for their patients and public good.

M. *Time* and *Newsweek*. Media network usage gave MSNJ statewide coverage and average shelf life in the doctor's office for three to four weeks. Releases included the following: If You're Over 60; Catastrophic Health Care; and Health Care's Latest Editions; and Let's Work Together.

N. Television. Public service announcements continue to be aired out of New York and Philadelphia commercial stations and New Jersey Network Public Broadcasting TV, using 15- to 30-second television tapes on Catastrophic Health Care; Health Care Cost Cutting; Older Americans; AIDS; Let's Work Together; and Cholesterol.

3. Special Programming.

A. Participation in New Jersey Network AIDS outreach commitment. This was a major TV campaign with a simulcast using a 40 plus radio station backup that blanketed the state for one week.

B. Participation on Governor's Committee on Child Abuse.

C. Support of Eye Health Screening Program.

D. Support of Task Force with Senior Citizens.

E. Participation in formation of Ad Hoc Committee on Graduates of Non-U.S. Medical Schools.

F. Participation in AMA Anti-Tobacco Postcard Campaign.

G. Participation in Mobil Oil Executive Retirement Social Enlightenment Program.

H. PR support of legislative activities by Katz Martin Brill & Company.

I. Development of annual public relations brochure for membership information.

J. Development of a television story on history of New Jersey medicine and MSNJ.

K. Development of a cooperative public relations promotion with hospitals, senior citizen centers, senior citizen newspapers, i.e. Fall Hazard Checklist and Fall Prevention Guide.

L. AMA Recognition—*Connection*, March 1988 (from the Genie advertisement).

M. The American Association of Medical Society Executives (AAMSE) selected MSNJ's program for inclusion in the AAMSE Management Resource Manual.

The Reference Committee recommended that the original report be filed.
HOUSE ACTION: Adopted. The report was filed.

Supplemental Report #1

Council on Public Relations

JOSEPH N. MICALE, MD, CHAIRMAN

(Reference Committee "D")

The Katz Martin and Brill Company continues to pursue the interest of the Medical Society of New Jersey in governmental/public relations activities.

Educating legislators, senior citizens, and the media about Senior Medical Courtesy afforded the Council on Public Relations one of many opportunities to showcase MSNJ in 1988. Our work also significantly strengthened the Society's efforts to fight legislative proposals mandating Medicare assignment.

Senior Medical Courtesy, MSNJ's alternative to mandatory Medicare assignment, assures seniors of modest means that they will receive care from a physician who accepts Medicare assignment. The voluntary program, organized by MSNJ and its 21 county societies, began as a pilot program in 1986 with the Union and Ocean County medical societies. Two years later, 18 of New Jersey's 21 counties had programs in place. Ten of these were established in the first nine months of 1988. By September 1988, more than half of MSNJ's 8,000-plus members were participating and more than 5,000 seniors had enrolled in programs.

Few outside the MSNJ community knew of Senior Medical Courtesy's progress. Letters and news stories during the year showed us that we needed to tell seniors, legislators, and the media about Senior Medical Courtesy.

A pamphlet was developed in September which explained the program and its eligibility guidelines. It was mailed to Governor Thomas H. Kean, all 120 legislators, New Jersey's commissioners of health, human services, and community affairs, and distributed to county offices on aging, senior citizen groups, and county medical societies. Each pamphlet also was accompanied by a personal letter from MSNJ President Palma E. Formica, MD.

We also created a Senior Medical Courtesy exhibit, designed to travel to trade shows and accompany physicians on their speaking engagements. The attractive eight-foot display (and the pamphlet) premiered in September at the "Senior Games of New Jersey." The annual one-day event is held at Kean College in Union and is sponsored in part by the Governor's Council on Physical Fitness and Sports and the New Jersey Department of Community Affairs. Assembly Speaker Chuck Hardwick and Department of Community Affairs Commissioner Anthony M. "Doc" Villane, Jr. and hundreds of seniors visited the booth and learned about the program from Doctors Formica, Joseph A. DiLallo, and Richard R. Lorber.

Letters and comments from legislators in response to our mailing were encouraging. One legislator requested an additional 1,000 pamphlets to distribute from her district office. And we learned just how well received the Senior Medical Courtesy program had become when the Assembly rejected a motion made by Assemblyman Alan Karcher in October to relieve the Assembly Health Committee of A-2305, his mandatory Medicare assignment bill.

Medicine's effectiveness in the Legislature has been strengthened by MedAC and JEMPAC, our political action committees. A new MedAC/JEMPAC exhibit reminded New Jersey's physicians just how important their contributions are when it premiered in April 1988 at MSNJ's Annual Meeting. The three-paneled tabletop display explained each PAC and included a drop-box for membership cards and contributions.

MSNJ reaffirmed its commitment of public health education in 1988 when it sponsored "On the Trail of a Killer," the New Jersey Network award-winning documentary on the search for effective treatments and a vaccine for AIDS. Sponsorship of the program provided us 19 on-air spots consisting of the Society seal, name, and voice-over that the program was being sponsored in part by MSNJ. MSNJ also received written credit in all advertisements which appeared in the *Star-Ledger*, *Trenton Times*, *Courier Post*, *Bergen Record*, and *TV Guide*.

New Jersey Network tells us that the program earned the highest viewership rating for local programming in the Philadelphia area in May. The documentary—which includes in its closing a built-in MSNJ on-air credit—subsequently has been distributed nationally to public broadcast system affiliates by the Central Educational Network, a distributor of public television network programs.

"On the Trail of a Killer" was awarded the Silver Medal at the New York International Film and Video Festival and has been selected to receive the CINE Golden Eagle Certificate to represent American cinematography in international competition.

The Council on Public Relations in 1988 compiled a media list of all medical writers and reporters at newspapers, radio, and television stations in New Jersey, New York City, and Philadelphia in an effort to build a legislative media relations program for MSNJ.

MSNJ's side of the issue in its long-running battle against the State Insurance Department's proposed surcharge on malpractice premiums received favorable media attention resulting from press releases which we distributed in the State House complex.

The Reference Committee recommended that Supplemental Report #1 be filed.

HOUSE ACTION: Adopted. The report was filed.

Council on Legislation

IRVING P. RATNER, MD, CHAIRMAN

(Reference Committee "D")

This report presents a summary of the ultimate status of legislative measures of the 203rd Legislature. The Council's operations, together with a cumulative report of MSNJ's official positions on current legislation, are reflected regularly in the official bulletins dispatched to state legislative keymen and to component societies, and in items published in the Membership Newsletter in *NEW JERSEY MEDICINE*, the journal of the Medical Society of New Jersey.

The Council on Legislation continues to invite an official representative from each specialty society to all Council meetings. A notice announcing the date of each of the Council's meetings also is sent to all MSNJ official intermediaries with New Jersey specialty societies.

The Council urges that more representatives attend its meetings so that it may have the benefit of the timely thinking of specialty societies concerning proposed legislation affecting the specialty fields.

The Council also invites the chairman or representatives of each council and standing committee to attend the legislative meetings. Recent bylaw amendments make it possible for one Auxiliary member, one resident member, and one student member appointed by the president, to serve on the administrative councils and committees for a one-year term to be full voting members of the representative council and committees.

Every other month there is a special section in *NEW JERSEY MEDICINE* dealing with legislative and regulatory updates. The status of all active MSNJ legislative matters is detailed.

Of the bills reported to the House from the First Session of the 203rd Legislature the following were signed into law:

S-1995—Ewing—Blood Banks (Immunity). Provides that volunteers providing services to blood banks shall be immune from civil liability unless they have acted in a willful, wanton, or grossly negligent fashion. *Approved.*

A-546—Genova—Immunization. Provides that students in public colleges must produce a medical history of their immunizations for preventable diseases. *Approved.*

The following is a list of bills of the 1988-1989 Legislature that were reviewed after the meeting of the 1988 House of Delegates.

SENATE

S-134—Russo—Local Boards of Health. Directs the commissioner of health to require the boards of health in Atlantic, Cape May, Monmouth, and Ocean counties to establish and maintain registries for cancer, birth defects, and hematological, renal, and hepatic diseases as well as neurological disorders caused by chemical pollution of water or air. *No Action.*

S-301—Dumont—Physical Therapy. Requires physical therapy treatment to be given under the supervision of a practitioner authorized to prescribe treatment. "Supervision" is defined as personally monitoring the progress of treatment and includes intermittent observation of treatment sessions. *Disapproved,* physicians already are responsible for the care rendered by physical therapists employed by them. This legislation is unnecessary and unworkable, and will impair rather than enhance the quality of care rendered.

S-490—Bubba—Surgical Consent. Requires express written consent to surgery except in cases of physical or mental incapacity or emergencies. The State Board, after consultation with the Health Department, the Medical Society, and the Hospital Association shall prescribe the consent forms which shall be used by physicians. *Conditional Approval,* pending amendment to the bill that would make it applicable to the rules and regulations of the hospital medical staffs.

S-550—Brown—Ombudsman for Children. Creates an office of ombudsman to monitor services rendered to children through the Department of Human Services. *Approved.*

S-594—Rice—AIDS. Requires the Department of Health to adopt rules to assure that hospitals accept their fair share of patients with AIDS or ARC. *Action Deferred,* pending further information from New Jersey Hospital Association.

S-882—Jackman—Unemployment Compensation and Temporary Disability Contributions. Amends existing law to make certain that dentists acting as independent contractors are not subject to

unemployment and disability taxes. (MSNJ has required the sponsor to include physicians and he has agreed.) **Active Support.**

S-906—Hurley—Withholding or Withdrawing of Services in the Event of Terminal Illness. Empowers adults to execute a statutory form of directive to their physicians providing for the withholding or withdrawing of life-sustaining procedures during a terminal illness. The directive would be valid for five years and provides immunity for physicians and other providers complying with such directive.

"Life sustaining" means a modality or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function which would serve only artificially to prolong the moment of death where in the judgment of the attending physician death is imminent whether or not such procedures are utilized. It does not include "the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain." **Action Deferred**, pending publication of the report of the Governor's Commission on Biomedical Ethics with status reports to be made to the Council on Legislation concerning the Commission's progress.

S-1177—Feldman—Privileged Communications. Extends privileged communications to psychiatric social workers and nurses. It also, by implication, advances the concept that persons other than physicians and psychologists may treat mental health conditions. **Disapproved**, since this bill gives psychiatric social workers and nurses the right to practice medicine without requiring demonstrated competence to do so.

S-1194—Feldman—Withholding or Withdrawing Life Support. Provides that persons 18 years of age or older can execute a directive regarding life-sustaining measures when that person no longer is able to express his own consent and his condition is terminal. **Action Deferred**, pending publication of the report of the Governor's Commission on Biomedical Ethics with status reports to be made to the Council on Legislation concerning the Commission's progress.

S-1242—Feldman—Surrogate Parenting. Establishes a commission to study surrogate parenting. **Action Deferred** (see S-1194).

S-1446—Zane—Organ Transplants. Establishes a commission on transplants to allocate transplant services for New Jersey residents. Out-of-state programs are not recognized if the service is available at a New Jersey hospital. **Disapproved**, a) this bill gives preference to medical schools, b) there is no provision for followup care, and c) is further compounded by conflicting federal regulations.

S-1475—McNamara—Hospital Beds. Establishes a demonstration project to allow hospitals to designate surplus acute beds as swing beds for skilled nursing care. **Action Deferred**, pending further information from New Jersey Hospital Association.

S-1508—Dalton—Health Insurance. Directs health insurers to provide insured with a written statement of the application of their policy to injuries sustained in auto accidents. **Approved.**

S-1541—Pallone—Food and Hydration. Requires food and hydration to be provided to all patients regardless of consent. Does not provide immunity to health professionals nor is a penalty for nonobservance provided. **Active Opposition**, because this bill would override the right of the patient or their legal representation to make reasoned decisions and would require health providers to use physical force and restraints.

S-1702—Bassano—AIDS. Makes AIDS a reportable disease. Grants immunity to physicians who deem it advisable to inform sexual partners of the patient's condition. **Approved.**

S-1730—Bassano—Viral Disease Research. Establishes a viral disease research bank through cooperation between the Department of Health and UMDNJ. **Approved.**

S-1938—Pallone—Medical Waste. Requires that all medical waste be incinerated by a licensed center. Manifest records must be maintained by the generators, i.e. doctors, dentists, hospitals, the transporters, and the incinerators. **No Action.**

S-2055—VanWagner—DRG Study Commission. Creates a study commission to determine whether the DRG program should be continued. **Active Support.**

S-2056—VanWagner—Medicaid. Mandates Medicaid coverage of alcoholism treatment provided in a hospital or certified treatment center on the order of a physician. **Action Deferred**, pending further information from MSNJ's Committee on Drug and Alcohol Abuse.

S-2105—O'Connor—Hospital Privileges for Dentists. Permits dentists to complete and authenticate hospital medical records. All patients admitted must be under the general supervision of a physician member of the medical staff. **Conditional Approval**, provided the bill is amended to assure that all patients are under the general care of a qualified physician who has performed a history and physical.

S-2120—McNamara—Health Insurance Mammograms. Requires health insurers to provide coverage for mammograms. **Approved.**

S-2152—Paterniti—Veteran Services. Authorizes a commission to study the medical needs of veterans. **No Action.**

S-2212—Lynch—Political Contributions. Amends the New Jersey election contribution laws. Limits PAC contributions to \$500 per candidate per election and \$2,500 per year. Also caps PACs at \$100,000 per calendar year. **No Action.**

S-2214—Paterniti—Nursing Services. Creates a commission to study the overall performance and employment conditions of nurses employed by the Department of Human Services. **No Action.**

S-2216—Paterniti—Osteoporosis. Establishes a commission (15 members) to compile and analyze data on osteoporosis, develop educational programs, and assist local health agencies in public education. **Disapproved**, osteoporosis is a well-known, researched, and publicized condition. There is no need to create a special legislative commission to conduct studies when comprehensive scientific literature readily is available.

S-2236—Ewing—Civil Immunity. Amends the good samaritan act to extend immunity to those responding to emergencies regardless of their lack of volunteer status. *Approved.*

S-2240—Ewing—AIDS. Requires physicians and hospitals to report patients with AIDS to the local board of health within 24 hours of diagnosis. (Does not require reports on patients HIV positive.) *Disapproved*, impractical and unnecessary, since AIDS already is reportable to the State Department of Health.

S-2241—Ewing—Tattoo Parlors. Authorizes the Public Health Council to regulate sanitary conditions in tattoo parlors. *Approved.*

S-2243—Ewing—AIDS. Requires persons suspected of venereal disease to submit to HLTV-III tests; requires applicants for marriage licenses to be tested and the physician to notify them in writing of the results on a form developed by the Department of Health; requires physicians to certify that they have tested applicants and notified them of the results. *Disapproved*, because this type of legislation has been enacted in other states, has failed, and either has been repealed or suspended.

S-2244—Ewing—Irradiated Foods. Declares irradiated foods to be adulterated if processed and treated with cesium 137. *Action Deferred*, pending further information from MSNJ's Council on Public Health.

S-2248—Ewing—AIDS (Prison System). Requires inmates in correctional institutions to be tested for AIDS. *Approved.*

S-2269—Orechio—Audiologists. Provides for a 180-day application period for audiologists eligible for "grandfathering" under the 1985 licensing act. *No Action* (Law c.185 P.L. 1988).

S-2343—Pallone—Medical Waste. Creates a medical waste disposal system whereby needles, syringes, and blood products would have to be disposed of by special permit. Physicians as generators would be required to register with the DEP. *Approved.*

S-2346—Russo—Water Pollution. Requires the Department of Health to determine the correlation between water pollution and illness. *No Action.*

S-2432—DiFrancesco—Rights of Psychiatric Patients. Guarantees rights of psychiatric patients in screening services and short-term care facilities. *Disapproved*, the bill, in its present form, prevents prompt, effective, and humane treatment of the mentally ill.

S-2461—Pallone—Fetal Alcohol Syndrome Prevention. Establishes a Fetal Alcohol Syndrome Prevention Program within the Division of Community Health Services of the Department of Health. No appropriation is included. *Action Deferred*, pending recommended amendments from the New Jersey chapter, American Academy of Pediatrics and further information from MSNJ's Committee on Drug and Alcohol Abuse.

S-2485—Stockman—Rights of Hospital Patients. Reaffirms many of the commonly accepted rights of patients. Additionally, requires the hospital to provide interpreters if 10 percent or more of the residents within the hospital service area speak the foreign language of the patient. *No Action.*

S-2493—Bassano—Pertussis Reaction. Provides that if a health provider has reason to believe a patient has had a major adverse reaction to the pertussis vaccine, the provider shall immediately note that fact in the child's medical record and notify the Department of Health of pertinent details within seven days. *Action Deferred*, pending further information from the New Jersey chapter, American Academy of Pediatrics.

S-2508—Rand—HMOs—Medicaid. Requires HMOs to accept a percentage of Medicaid patients into their program. *No Action.*

S-2509—Lynch—Physical Modalities. Provides that physicians, chiropractors, and podiatrists may not use unlicensed aides to provide physical modalities. *Active Opposition*, this bill would increase the cost of health care, is unnecessarily restrictive, and will produce a problem of access for many patients. Safe applications of simple physical modalities can be done by patients, parents, friends, and unlicensed aides—they should not be restricted to registered therapists.

S-2511—Ewing—Prisoners/AIDS-HIV Sensitivity. Provides that all prisoners shall be tested for sensitivity to HIV. *Approved.*

S-2523—McNamara—Certificate of Need Study Commission. Creates a CON study commission to determine if and under what conditions the program should be continued. *Approved.*

S-2592—DiFrancesco—Occupational Therapy. Provides for the licensing and regulation of occupational therapy. *Active Opposition*, because MSNJ is generically opposed to the creation of new professional boards.

S-2598—McManimon—Notification to Funeral Directors. Requires that the person making a determination of death or who otherwise has knowledge of the patient's HIV sensitivity must provide written notification with the remains of the deceased for the funeral director. *No Action.*

S-2611—Rice—Hospital Care for Indigents. Permits certain municipalities to require indigent patients to go to the least expensive hospital. *Disapproved*, because this legislation would unnecessarily restrict the choice of patients and their doctors, produce dangerous delays, and conflict with several current statutes.

S-2614—Cardinale—Education. Requires public schools with sex education programs to emphasize that abstinence is the best assurance of avoiding sexually transmitted diseases and pregnancy. *No Action.*

S-2633—Jackman—Medical Education. Permits hospitals to enter into educational agreements for clinical clerkships with any medical school without the prior approval of the State Board of Medical Examiners. *Disapproved*, there is no way to authenticate the quality of education in certain foreign medical schools, therefore, the approval of the State Board of Medical Examiners provides a needed and valuable counterbalance.

S-2636—Brown—Hospital Care of the Elderly. Expands the jurisdiction of the state ombudsman to acute care hospitals. *Active Opposition*, hospitals have well-defined quality assurance and patient protection programs. They are used to providing acute care. It is impractical, impossible, and misguided to interject the ombudsman concept into our acute care hospital system.

S-2673—Lesniak—Corporate Immunity. Provides that officers and directors are immune from suits by members or shareholders when acting in good faith unless there is a material conflict of interest. *Active Support*.

S-2759—Codey—Graduate Medical Education. Adds the dean of the School of Graduate Medical Education at Seton Hall to the Advisory Council on Graduate Medical Education. *Approved*.

S-2788—Costa—Health Care Professional Supply Advisory Commission. Creates a commission to study the supply of available personnel and to develop recommendations for alleviating defined shortages. *Disapproved*, unnecessary legislation, this problem already is being addressed by the appropriate organizations.

S-2858—Lesniak—No Fault. Makes PIP coverage optional if the insured has other health coverage. *Disapproved*, many drivers do not have health insurance and many persons that do have it, because of employment or student status, become ineligible. This bill would produce many gaps in coverage and consequently, result in service disruption.

S-2907—Bassano—Medicaid. Extends hospice coverage to Medicaid. *Approved*.

S-2918—Codey—Lupus Registry. Declares lupus a reportable disease and creates a registry within the Department of Health. *Disapproved*, already being done on a national level. State Public Health Council has the authority to establish a registry when indicated.

S-2919—Codey—Lupus Treatment. Creates a lupus treatment demonstration project within the Department of Health with a seven-person advisory committee. *Disapproved*, education and treatment program already being done in physicians' offices throughout state.

S-2920—Codey—Medical Waste. Provides for rewards for reports which lead to the conviction of illegal medical waste disposers. *Disapproved*, bounty systems encourage reckless conduct. If there is validity to the concept, it should first be tested for the crimes of murder, rape, and robbery.

S-2921—Russo—Drug Abuse. Establishes a Governor's Council on Alcoholism and Drug Abuse to coordinate the various programs by various governmental agencies. *Disapproved*, since both divisions have functioned well separately, there is no need for this legislation.

S-2936—Codey—Medical Licensing and Discipline. This bill would revise the current State Board system by requiring enhanced and more comprehensive reporting of impaired or incompetent physicians. At the same time it removes the State Board of Medical Examiners and the Attorney General's offices from certain conflicts by having a separate panel make initial decisions. A clear burden of proof is established and further enhancements regarding due process have been recommended by MSNJ special counsel, Herbert J. Stern. *Conditional Approval*, pending acceptance of amendments to the bill as submitted by MSNJ.

S-2939—VanWagner—Emergency Services. Appropriates \$1.5 million to the Department of Health to be used for EMS training and equipment. *Action Deferred*, pending further information from MSNJ's Committee on Emergency Medical Care.

S-2947—Orechio—AIDS. Requires the Department of Health to file reports related to ARC, AIDS, and HIV positive patients to local health officers on a regular basis. *Disapproved*, local health officers currently have access to these statistics.

SR-63—Russo—Handguns. Requests Congress to ban the manufacture, sale, purchase, transfer, receipt, or transportation of handguns. *No Action*.

ASSEMBLY

A-13—Kavanaugh—Commercial Surrogate Parenting. Prohibits the payment of money for surrogate parenting purposes. *Action Deferred*, pending publication of the report of the Governor's Commission on Biomedical Ethics with status reports to be made to the Council on Legislation concerning the Commission's progress.

A-124—Villane—Medical Waste. Regulates the disposal of medical waste through a complex system which would require every doctor and dentist to register with the Department of Health and to use a manifest system which includes the filing of detailed quarterly reports. *No Action*.

A-163—Rocco—Certificate of Need. Provides that certificate of need shall expire after two years unless financing contracts, and necessary variances are obtained. *Approved*.

A-176—Rocco—Reimbursement for Physiological Laboratory Services. Provides that physiological laboratories performing diagnostic testing services at the request of physicians shall be permitted to bill Blue Shield directly. *Disapproved*, because there are no announced licensing standards in the bill. The New Jersey Insurance Department is not equipped to regulate and license a health profession. There is no recognized profession related to "physiological laboratory services."

A-250—Felice—Methadone Registry. To establish a central registry of persons enrolled in methadone programs. *Disapproved*, because this legislation would be impractical and expensive—also such a registry reflects an approach to a problem that is no more than minimal.

A-267—Felice—Pharmacy. Prohibits institutions from operating retail pharmacies within 1,500 feet of their facility. (N.B. This bill conditionally vetoed by the governor at the end of the 1987 session.) *Active Opposition*, this bill is anticonsumer and detrimental to the future efforts of hospitals and physicians to diversify services in order to meet cost-containment goals.

A-415—Deverin—Respiratory Therapists. Licenses and regulates respiratory therapists to function under the direction or supervision of a licensed physician. The State Board of Medical Examiners would be the licensing agency. *Disapproved*, there is no demonstrated need to create the licensed profession of respiratory therapy.

A-448—Pelly—Impaired Health Professionals. Directs the boards responsible for licensing certain but not all health professionals to institute impaired professional programs. Professional societies would contract with the respective boards to administer the program. There are no details regarding qualifications of personnel or funding. *Active Opposition*, confidentiality is not possible with this legislation. MSNJ currently is working on legislation concerning impaired health professionals; it is recommended that reference to physicians be deleted from this bill since a well-structured and voluntarily financed program already is in place.

A-472—Colburn—Certificate of Need. Creates an exemption from certificate of need requirements when the hospital and two or more physicians joint venture a project that costs less than \$2 million. *Approved*.

S-535—Genova—Blood Donations. Provides that it is a disorderly persons offense to donate blood with knowledge that the donor has a communicable disease. *Disapproved*, this legislation, as written, is unworkable and gives an overall negative impact concerning the blood donor program.

A-594—Haytaian—Handguns. Provides that handgun purchase permits shall be valid for five years. *Disapproved*, the bill unwarrantedly liberalizes (five-year grace period) current law and exposes the public to injury and death.

A-799—Otlowski—Certificate of Need. Exempts home health agencies from the CON law. *Approved*.

A-887—Kern—Medical Directives. Establishes a procedure and system for execution of medical directives and medical powers of attorneys. *Action Deferred* (see A-13).

A-954—Kern—In Vitro Fertilization. *Action Deferred* (see A-13).

A-956—Kern—Surrogate Motherhood. *Action Deferred* (see A-13).

A-957—Kern—In Vitro Fertilization. *Action Deferred* (see A-13).

A-963—Kern—Anatomical Gifts (anencephalic infants). *Action Deferred* (see A-13).

A-979—Kern—Medical Directives for the Terminally Ill. *Action Deferred* (see A-13).

A-988—Cooper—Autopsy. Requires county medical examiners to make autopsy reports available to family members within 45 days of request. *No Action*.

A-1043—Singer—Abused Elderly. *Action Deferred* (see A-13).

A-1157—Bryant—Withholding Medical Treatment. *Action Deferred* (see A-13).

A-1412—Randall—Outpatient Adolescent Drug and Alcohol Treatment Programs. Requires standards for outpatient adolescent drug and alcohol treatment programs. *Conditional Approval*, pending inclusion of two MSNJ-appointed physicians to the Advisory Task Force.

A-1632—Doyle—Incorporation of Nurses/Physical Therapists. Allows nurses and physical therapists to form professional service corporations. Also allows them to be shareholders in the corporations of doctors and dentists. *Disapproved*, nurses and physical therapists do not have a license that is comparable to the medical or dental license. While they can be allowed to incorporate, they should not be permitted to be a shareholder in a corporation providing medical and/or dental services.

A-1718—Martin—Nursing Education. Directs Rutgers to establish a doctoral program in nursing. *Approved*.

A-1734—Martin—Drug Testing/Student Athletes. Requires high school students to be tested for drug abuse. *Action Deferred*, pending further information from MSNJ's Committee on Drug and Alcohol Abuse and Committee on Medical Aspects of Sports.

A-1774—Kern—Governor's Council on Substance Abuse. Creates a 24-member Governor's Council on Alcoholism and Drug Abuse and merges the existing Division of Alcoholism and the Division of Narcotic and Drug Abuse Control within the Department of Health into a new Division of Alcoholism and Drug Abuse Control. It would coordinate all programs within the state and make program and funding recommendations to the governor and the Legislature.

The governor is to appoint an independent evaluator who would conduct a study and file a report on the efficacy of the Council four years after enactment of the legislation. *Disapproved*, since both the Division of Narcotic and Drug Abuse Control and the Division of Alcoholism function well as separate divisions, there is no need for this legislation.

A-1842—Frelinghuysen—Medicaid. Extends Medicaid to children within the federal poverty level. *Approved*.

A-1843—Hendrickson—Patient Bill of Rights. Details the rights of patients in acute care hospitals. *Disapproved*, pending deletion of the litigation option of the bill, since it will produce unnecessary delays and cost patients extra expense. Further, there should be a clause or section added to the bill recognizing that patients have certain obligations to cooperate in their treatment and to comply with advice and directions.

A-1868—Doyle—Public Health. Requires physicians to file reports with county health departments regarding illnesses caused by chemical pollutants. *Action Deferred*, pending further information from MSNJ's Council on Public Health and the county presidents of Atlantic, Cape May, Monmouth, and Ocean counties.

A-1884—Zecker—Civil Immunity. Permits certain nonprofit corporations to extend immunity to trustees, directors, officers, members, or employees when exercising judging of discretion. *Active Support*.

A-1898—Miller—Professional Liability—Statute of Limitations. Establishes a 3-year statute of

limitations in tort actions against health care providers. Children would have until 11 to bring an action for injuries prior to age 8. After age 8 they come under the 3-year standard. Fraud, concealment, and unintentional foreign bodies "toll" the statute. **Active Support.**

A-1899—Miller—Affidavit of Merit. Provides that within 60 days of filing a medical malpractice complaint, the plaintiff must supply an affidavit, by a qualified expert, that reasonable cause exists to believe malpractice occurred. **Active Support.**

A-1905—Miller—Public Health/Sulfites. Requires public eating places to post notices if their food contains sulfites. **Approved.**

A-1969—Girgenti—Structured Payments. Provides for structured settlements when future damages exceed \$150,000. **Active Support.**

A-2015—Loveys—Uniform Anatomical Gift Act. Provides for the redesign of the driver's license to incorporate organ donation information on the license itself. **Approved.**

A-2065—McEnroe—Nurse Midwife. Requires the commissioner of health to establish a two-year nurse midwife prenatal program at the East Orange Family Health Center. **Action Deferred,** pending further information from the New Jersey section of the American College of Obstetricians and Gynecologists.

A-2070—McEnroe—Drug Abuse. Requires the Department of Health to distribute to physicians a booklet to be distributed to the public regarding cocaine use during pregnancy. **Disapproved,** physicians caring for pregnant women regularly warn against the use of tobacco, alcohol, and other drugs during pregnancy. State of the art literature is available from a wide range of national scientific sources. The Department of Health does not have capacity to produce and distribute materials of comparable quality.

A-2097—Doyle—Emergency Services. Requires volunteer emergency personnel to be certified either through the State First Aid Council or the Department of Health. **Approved.**

A-2120—Mattison—AIDS. Requires hospitals to accept fair share of AIDS patients. **Disapproved,** it is unnecessary and unworkable. Incentives, not mandates, should be given to hospitals to accept their fair share of AIDS patients. The State Health Department is setting up programs to assure that no hospital is overburdened with AIDS patients.

A-2139—Stuhltrager—Organ Donation. Requires hospitals to report organ donation data to the Department of Health. **No Action.**

A-2142—Stuhltrager—Tobacco. Prohibits the sale of tobacco to minors. **Approved.**

A-2148—Stuhltrager—Biochemical Disorders. Requires the Department of Health to provide for the screening and treatment of certain biochemical disorders in newborns. (Law c.24 P.L. 1988)

A-2253—Baer—Sulfites. Prohibits wholesale or retail distributors of food or food products from adding sulfites to their products. **Disapproved,** in favor of A-1905.

A-2276—Kern—Auto Coverage. Extends PIP coverage to passengers on commercial vehicles. **Approved.**

A-2284—Rooney—Vision Screening/Preschool. Establishes a preschool vision screening for children three to five years of age. **Approved.**

A-2318—Bush—AIDS and AIDS-Related Conditions. Requires that AIDS and AIDS-related conditions be reported to the Department of Health. Information may be released only when patient consent or certain other situations are present. **Disapproved,** Department of Health already has tracking programs in process.

A-2372—Rooney—Nutritionists. Licenses and regulates the practice of nutrition and creates a state Board of Nutrition. **Disapproved,** no demonstrated need to create a licensed profession.

A-2381—Kelly—Food Irradiation. Declares that food exposed to ionized radiation is adulterated. **Disapproved,** there is no scientific evidence that irradiation is harmful.

A-2485—Haytaian—Financial Interests in Referred Services. When referring patients for services to a practice where they have a significant interest, requires physicians, chiropractors, and podiatrists to disclose that fact to the patient. **Active Support.**

A-2488—Colburn—Pertussis. Provides that adverse reactions to pertussis vaccine must be promptly recorded and a report forwarded to the Department of Health within seven days. **Approved (Law c.128 P.L. 1988).**

A-2499—Smith—Fetal Alcohol Syndrome. Establishes a (FAS) education and prevention program in the Department of Health and appropriates \$700,000. **Action Deferred,** pending further information from MSNJ's Committee on Maternal and Child Care and the Committee on Drug and Alcohol Abuse.

A-2506—Rocco—Blood Banks. Extends certain immunities to trustees and volunteers of blood banks. **Approved.**

A-2511—Bush—Medicaid. Provides that Medicaid coverage for mammograms shall be consistent with federal policy. **Approved.**

A-2512—Bush—Health Insurance/Mammograms. Provides that health insurers must pay for mammograms. It does not apply to routine screening. **Approved.**

A-2524—Miller—AIDS. Requires a physician to disclose positive results of AIDS test to patient's spouse. **Conditional Approval,** pending the following amendments:

1. The word "spouse" be changed to known sexual contacts and needle-sharing contacts.
2. Positivity must be verified by a confirmatory test.
3. In Line #11 the word "shall" be changed to "may" and in the statement the word "require" to be changed to "urge."
4. Throughout the bill HTLV-III be changed to "HIV."

It was further recommended that if the sponsor objects to any of the foregoing amendments that MSNJ changes its position to **Disapproved**.

A-2545—Singer—Smoking. Requires restaurants with a seating capacity of 50+ to have a non-smoking area separated by floor to ceiling partitions and also to install air cleaning and recirculation equipment. **No Action.**

A-2601—Kline—AIDS. Provides that patients must consent, in writing, to HIV testing except under certain circumstances. **Disapproved**, written consents for HIV sensitivity are impractical and unnecessary.

A-2635—Riley—Nursing Work Hours. Provides that nurses working in excess of 40 hours during any seven-day period must be paid time and a half for those hours exceeding 40. Also, provides that 16 hours be the limit for any given day and 24 hours the maximum during any 48-hour period. **No Action.**

A-2672—Zecker—Pension Funds. Exempts pension funds from attachment except in family law cases. **Approved.**

A-2709—Farragher—Education. Prohibits the offering of school-based health services regarding pregnancy, birth control, or abortion. Also prohibits counseling regarding family planning or abortion. **Conditional Approval**, pending an amendment to allow educational and counseling service provisions.

A-2751—Moran—Professional Licensing. Creates a commission to review licensing legislation being proposed by any legislator. The commission is to file a report with the governor and the Legislature on the necessity of establishing the licensing mechanism being reviewed. **Approved.**

A-2796—Rocco—Hypodermic Needles. Increases the penalty for the illegal disposal of hypodermic needles and syringes. **Approved.**

A-2844—Singer—Water Pollution. Requires the Department of Health to conduct a study of the impact of coastal water pollution on health. Appropriates \$1 million. (**Law c.59 P.L. 1988**)

A-2853—Villane—Medical Waste. Regulates the disposal of medical waste through a separate hauling and labeling system. It would include physicians and provide for an annual registration fee of up to \$100. The bill focuses on needles, syringes, blood, and blood products. **Approved.**

A-2859—Schluter—Motor Vehicles. Extends the implied consent law to blood and urine samples for drug and alcohol intoxication. **Approved.**

A-2860—Schluter—Motor Vehicles. Makes certain technical corrections to the blood alcohol and breath testing technique.

Also, makes it a violation to permit someone with a .10 or greater concentration to drive a car you own. **Disapproved**, unworkable, impractical legislation.

A-2938—Ogden—Communicable Disease. Requires health care facilities to notify first aid, ambulance, or rescue squads that the patient they are transporting has a communicable disease when that fact is known to the facility. **Approved.**

A-2942—Smith—Pap Smears. Requires the Department of Health to establish quality control standards for laboratories conducting pap smears. **Disapproved**, covered under existing New Jersey statute.

A-2958—Schuber—Laboratory Services. Exempts local health agencies from the requirements of the Clinical Laboratory and Improvement Act. **Disapproved**, government laboratories should be held to the same standards as anyone else doing the same task.

A-2968—Bush—Emergency Services (Immunity). Grants salaried or compensated emergency personnel with good faith immunity. **Approved.**

A-2970—Kline—AIDS Research Advisory Committee. Establishes an AIDS Research Advisory Committee within the Department of Health. **Disapproved**, Research Advisory Committee already in effect at federal level as is extensive research program.

A-2972—Roma—AIDS Prevention. Establishes a division of AIDS prevention and control within the Department of Health. **No Action.**

A-2983—Singer—Nursing Salaries. Provides that the minimum salary for RNs employed in state facilities shall be set at \$27,500 and increased to \$30,000 within two years. **Approved.**

A-3034—Kline—AIDS Advisory Council. Establishes an AIDS advisory council within the Department of Health. Does not provide for specific MSNJ representation. **No Action.**

A-3060—Singer—Nursing Services in State Facilities. Creates a committee to study the quality of nursing services in state-operated facilities to evaluate what must be done to assure quality nursing services. **Action Deferred**, pending further information from New Jersey Nursing Association.

A-3083—Kelly—Audiologists. Extends the "grandfather" period for audiologists and speech pathologists. **No Action.**

A-3084—Felice—Food and Hydration. Provides that food and hydration may not be withheld from any patient. **Action Deferred**, pending further information from MSNJ's Committee on Biomedical Ethics.

A-3106—Kavanaugh—Medicaid (HMO). Requires Medicaid to negotiate a reasonable reimbursement schedule with HMOs. The HMO then would be required to take a reasonable percentage of Medicaid patients. **No Action.**

A-3127—Smith—Lupus Registry. Establishes a lupus registry and requires physicians to report all known cases to the registry. **Disapproved**, the State Public Health Council has the authority to establish a registry when indicated.

A-3128—Smith—Lupus Treatment. Directs the Department of Health to establish a lupus treatment, education, and research demonstration program and appropriates \$750,000. **Disapproved**, already being done in physician offices throughout the state.

A-3130—Loveys—Organ Donations. Directs the Division of Motor Vehicles to redesign the driver's license so that the organ donation form is a part of it. **Approved.**

A-3135—Franks—Police and Fire Disability. Permits police and firemen who receive heart transplants to retire on special disability. *No Action.*

A-3141—Kavanaugh—Motor Vehicle. Requires that any driver involved in an accident which produces serious injury shall be tested for alcohol intoxication. *Approved.*

A-3142—Randall—Fetal Alcohol Syndrome. Requires sellers of alcoholic beverages to publish a warning regarding FAS. *Approved.*

A-3166—Impeveduto—Physical Modalities. Provides that physicians, chiropractors, and podiatrists may not employ unlicensed aides to administer physical modalities. *Active Opposition*, this bill would increase the cost of health care, is unnecessarily restrictive, and will produce a problem of access for many patients. Safe applications of simple physical modalities can be done by patients, parents, friends, and unlicensed aides—they should not be restricted to registered therapists.

A-3191—Randall—Tobacco Warnings. Requires sellers of tobacco to post signs warning of the hazards of smoking during pregnancy. *No Action.*

A-3206—Bush—Nursing. Creates a committee to review the employment practices of the state government regarding nurses to recommend methods to assure that high-quality staffs are available. *Action Deferred*, pending further information from the New Jersey Nurses Association.

A-3267—Miller—Professional Licenses. Amends current law to provide that current medical and nursing licenses will remain in effect until the renewal application is acted upon. *Approved.*

A-3271—Shusted—Dialysis. Creates a system for training and certifying dialysis technicians. *Active Support.*

A-3296—Zangari—Workers' Compensation. Provides that chiropractors' services are included in the definition of medical services under workers' compensation. (Chiropractic services have been included under workers' compensation allowances for over 20 years.) *Active Opposition*, chiropractic services should not be included in the definition of medical services since certain types of injuries are beyond the scope of chiropractors' treatment.

A-3352—Shusted—Peer Review. Adopts the provisions of the Federal Health Care Quality Improvement Act with the immunities granted. (The federal law which grants immunities also has certain required reporting.) Hospitals which do not report to or access the federal data bank are subject to penalty. *Disapproved*, in favor of proposed Senate Bill No. 2936.

A-3374—Foy—Workers' Compensation. Grants workers free choice of physician and hospital. *Approved.*

A-3420—Spadaro—AIDS. Creates the AIDS Vaccine and Drug Research and Development Grant Program. *Disapproved*, these programs are already in effect through federal programs.

A-3460—Smith—Trauma Centers. Requires the commissioner of health to designate a regional trauma center in central New Jersey. *Disapproved*, the commissioner of health should have the prerogative to designate regional trauma centers. The commissioner should not be forced by legislative mandates to make these decisions. If the certificate of need law is not working, it should be repealed.

A-3468—Loveys—State Athletic Control Board Medical Advisory Council. Permits the governor to substitute chiropractors for dentists or physicians on the Medical Advisory Council. *Active Opposition*, chiropractors cannot become members of the Medical Advisory Council since many types of injuries are beyond the scope of chiropractics.

A-3476—Colburn—Uncompensated Care. Restricts uncompensated care reimbursement at 7 percent; pays 97 percent of the excess with state monies; deducts the remaining 3 percent from hospital revenues; requires hospitals to accept Medicaid rates for indigent emergency room cases. *No Action.*

A-3537—Felice—Contact Lenses. Creates a State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians. Permits that Board to license contact dispensers. *Disapproved*, the fitting of contact lenses exposes patients to certain eye injuries. The task, therefore, requires the care, skill, and experience of optometrists and physicians.

A-3563—Kern—AIDS. Authorizes disclosure to certain person of parolees with AIDS. *Disapproved*, the bill, as written, has no provisions for confidentiality and there is no companion bill or current legislation which requires reporting by any governmental organization of HIV positivity.

A-3574—Franks—Autopsy. Allows verbal consent for autopsy. *Approved.*

A-3603—Felice—Medical Waste. Requires hospitals to package special medical waste in red bags marked with the international biohazard warning symbol and inscription. *Disapproved*, in favor of S-2343/A-2853, the Comprehensive Medical Waste Management Act.

A-3677—Spadaro—Medical Waste. Makes it a crime to dispose of medical waste other than in compliance with the Solid Waste Management Act. *Action Deferred*, pending further information from MSNJ's Committee on Environmental Health.

A-3736—Duch—Criminal Responsibility. Provides for the commitment of persons who are acquitted because of mental disease or defect if the defendant is a danger to himself or others. *Action Deferred*, pending further information from MSNJ's Council on Mental Health.

A-3737—Duch—Home Health Care. Establishes a demonstration project within the Department of Human Services to provide home health care to functionally and cognitively impaired seniors or disabled persons under the Social Security Act. *Approved.*

A-3738—Girgenti—Orthotists and Prosthetists. Provides for the licensing and regulation of orthotists and prosthetists through an advisory committee in the Division of Consumer Affairs.

Physicians are exempted from the requirements of the act. *Action Deferred*, pending further information from the New Jersey Orthopaedic Society.

A-3781—Roma—Health Insurance. Requires all health insurers to provide reimbursement for mammograms, pap smears, and infertility tests. (The bill does not clearly state whether screening tests are included.) *Action Deferred*, pending further clarification of the bill to determine whether routine screening is included in the reimbursement.

A-3790—Otlowski—Involuntary Commitment. Changes the effective date of (P.L. 1987, c.116) from May 1989 to November 1989. *No Action*.

A-3804—Littell—Ambulance, Fire, Rescue Squads. Prohibits the formation of local, regional, or statewide EMS coordinating areas. *Action Deferred*, pending further information from MSNJ's Committee on Emergency Medical Care.

A-3819—Schluter—No-Fault. Establishes a verbal threshold. Suits would be allowed for noneconomic loss only when the injury resulted in death, serious impairment of a body function, or permanent serious disfigurement. *Approved*.

A-3838—Randall—Hospital Records. Authorizes the commissioner of health to set fees for the copying of hospital records. *Disapproved*, because the bill is an unnecessary intrusion into management function.

A-3842—Bush—Blood Donors. Allows persons over age 65 to donate blood. *No Action* (unnecessary legislation).

A-3843—Bush—Infant Mortality. Creates a commission on infant mortality consisting of 15 members. Four members would be physicians. *Approved*.

A-3844—Bush—Cancer Research. Provides that a portion of the surtax on cigarettes be dedicated to the Cancer Research Fund. *Approved*.

A-3880—Moran—Podiatry. Declares that podiatrists are "physicians" within the scope of their licensing act. *Disapproved*, because the wording of such legislation would mislead the public into assuming that "podiatrists" are fully licensed physicians. If the intent of this bill relates to insurance reimbursement, it should be drafted to change the insurance code.

A-3933—Stuhltrager—Medicaid. Requires Medicaid program to cover hospice services. *Approved*.

AJR-72—Miller—AIDS Correction Facilities. Creates a commission to study the problem of AIDS among inmates in correctional facilities. *No Action*.

AJR-84—Foy—AIDS. Calls for voluntary compliance in workplace with AIDS "bill of rights"; requires various departments to report on AIDS policies and programs. *Approved*.

ACR-78—Girgenti—Social Security and Medicare. Memorializes Congress to insure that the federal government takes no action to jeopardize the benefits of Social Security and Medicare. *No Action*.

AR-25—Mazur—UCR Fee Schedules. Directs the Assembly Insurance Committee to study the use of UCR schedules by health insurers and to make recommendations that it deems necessary to regulate their use. *No Action*.

AR-29—Farragher—Medicare Fees. Requests Congress to raise fees to doctors participating in Medicare. *Conditional Approval*, pending amendment to include all physicians treating Medicare patients.

AR-98—Colburn—Foreign Nurses. Requests Congress to allow foreign nurses to extend their stay in the U.S. beyond the expiration of their work visa. *Approved*.

AR-114—Hardwick—AIDS. Requires certain AIDS counseling information for pregnant women. *No Action*.

The Reference Committee recommended that the original report be filed.

HOUSE ACTION: Adopted. The report was filed.

Council on Legislation

IRVING P. RATNER, MD, CHAIRMAN

(Reference Committee "D")

At 12 o'clock noon, Tuesday, January 10, 1989, the Senate and General Assembly met for organization of the Second Annual Session of the 203rd New Jersey State Legislature. As the Legislature presently is constituted, the Senate has a total of 40 members consisting of 16 Republicans and 24 Democrats. The Assembly has a total of 80 members consisting of 41 Republicans and 39 Democrats. By means of official legislative bulletins, the Society's official legislative positions on all current state legislation are regularly called to the attention of legislators as well as component societies, cooperating agencies, county keymen, county society executive directors, and executive secretaries.

The Society has adopted the following regular range of official positions concerning proposed legislation:

Watch List . . . For all approved/disapproved legislation.

Active Support . . . All-out support for the measure.

Active Opposition . . . All-out opposition for the measure.

Note and File . . . For all no action legislation.

Conditional Approval . . . To indicate that the approval of the Society is conditional, subject to elimination of the unsatisfactory elements of the bill that are pointed out.

Action Deferred . . . Pending amendment that will have substantial impact on active support/active opposition legislation.

The following bills were signed into law since the compilation of the Council on Legislation's Annual Report.

S-2673-Lesniak—Corporate Immunity. Provides that officers and directors are immune from suits by members or shareholders when acting in good faith unless there is a material conflict of interest. **Active Support.**

S-2343-Pallone—Medical Waste. Creates a medical waste disposal system whereby needles, syringes, and blood products would have to be disposed of by special permit. Physicians as generators would be required to register with the DEP. **Approved.**

A-130-Penn—Motor Vehicle Vision Examinations. Provides that a licensed ophthalmic dispenser may certify successful completion of the required visual examination for an operator's license. **Disapproved.**

CURRENT LEGISLATION

The Council offers this Supplemental Report #1 covering items dealt with since the compilation of its Annual Report.

SENATE

S-216-DiFrancesco—Board of Chiropractic Examiners. Creates a separate licensing and regulatory board for chiropractic. **No Action.**

S-938-Hurley—First Aid Districts. Provides that municipalities can adopt ordinances designating first aid districts. Each of the districts will become separate corporate bodies. All squads within the district are to be under the general supervision of the district authority. **Disapproved,** pending requested amendments from MSNJ's Committee on Emergency Medical Care.

S-2214-Paterniti—Nursing Services. Creates a commission to study the overall performance and employment conditions of nurses employed by the Department of Human Services. **No Action.**

S-2244-Ewing—Irradiated Foods. Declares irradiated foods to be adulterated if processed and treated with cesium 137. **Disapproved,** because there is no evidence of public harm from irradiated foods.

S-2458-McManimon—Medicare Information (same as A-2597). A supplemental appropriation to the Department of Health to implement a Medicare telephone information system. **No Action.**

S-2507-DiFrancesco—Medic Alert. Establishes the Medic Alert Demonstration Program, appropriates \$330,000. **Approved.**

S-3076-Paterniti—Heimlich Maneuver. Requires school boards to distribute Heimlich maneuver educational materials. **Approved.**

S-3079-VanWagner—Immunity. Requires physicians and others to report patients who have made defined threats against third parties to the local police. Grants civil immunity to the reporting practitioner. **Approved.**

S-3089—Stockman—Alzheimer's Disease. Designates November as "Alzheimer's Disease Awareness Month." **Approved.**

S-3091—Jackman—Dialysis. Creates a system for training and certifying dialysis technicians. **Approved.**

S-3104—Lipman—AIDS. Makes AIDS or HIV sensitivity reportable to the Department of Health and provides for confidentiality. **Action Deferred**, pending further information from MSNJ's AIDS Task Force on this bill as amended.

S-3149—Ewing—Fetal Alcohol Syndrome (FAS). Requires retail establishments (alcohol) to post warnings about alcohol consumption during pregnancy. **Approved.**

S-3236—Rice—AIDS. Requires that persons convicted for using CDS shall be tested for AIDS and HIV sensitivity. **Action Deferred**, pending further information from MSNJ's AIDS Task Force.

S-3303—Graves—Anabolic Steroids. Requires the commissioner of health to study whether anabolic steroids should be classified as schedule II drugs and makes it a crime to distribute them without a prescription. **Conditional Approval**, pending notification that anabolic steroids will not be added to the schedule II listing.

S-3304—Cardinale—HMO. Prohibits the use of sex as a rating factor in HMO coverage. **No Action.**

S-3315—Bassano—Anabolic Steroids. Expands substance abuse education to include anabolic steroids and further provides for testing and referral for treatment. **Approved.**

S-3440—Codey—Generic Substitution/Prescription Blank Change. Changes prescription forms to facilitate use of generic drugs. **Active Opposition**, generic substitution is a questionable concept that must not be advanced without safeguards and testing. Generic drugs have not been tested through FDA-approved clinical trials. At this time, the FDA is reviewing the generic issue. Liberalization of the generic law is not indicated at this time.

SJR-77—Ambrosio—AIDS/Workplace. Calls for voluntary compliance in workplace with AIDS "bill of rights"; requires various departments to report on AIDS policies and programs. **Approved.**

SJR-79—Graves—Health Care Facilities and Providers. Establishes a commission to study the feasibility of an expanded system of hospital-based nursing schools. No MSNJ representation is provided. **Conditional Approval**, pending deletion of the word "free" from line 23 and the addition of a "physician" to the commission.

The Reference Committee recommended that Supplemental Report #1 be filed.

HOUSE ACTION: Adopted. The report was filed.

Supplemental Report #2

Council on Legislation

IRVING P. RATNER, MD, CHAIRMAN

(Reference Committee "D")

CURRENT STATE LEGISLATION

The Council offers this Supplemental Report #2 covering items dealt with since the compilation of its Supplemental Report #1.

ASSEMBLY

***A-865—Otlowski—Mental Health/Involuntary Treatment.** Assures persons receiving treatment on an involuntary basis in either a screening service or short-term facility of the same rights as patients who have been involuntarily committed to state or county psychiatric facilities. **Disapproved**, the rights as defined in this bill are unworkable in a facility set up to handle stays of a 24-hour duration. These issues should be established by institutional codes of behavior rather than state law.

***A-1734—Martin—Drug Testing/Student Athletes.** Requires high school students to be tested for drug abuse. **Disapproved**, because of the lack of confidentiality in this bill; also, it is potentially unconstitutional and discriminatory because it is only directed to students who participate in interscholastic athletics and certain other programs.

***A-1868—Doyle—Public Health.** Requires physicians to file reports with county health departments regarding illnesses caused by chemical pollutants. **Disapproved**, MSNJ is in agreement with the intent

of this legislation, but has significant reservations about its implementation since the many bathers that use the ocean annually are tourists which makes followup impossible. MSNJ urges the Department of Health to explore other avenues to maintain the waters of the New Jersey coast to prevent environmentally induced illnesses. (MSNJ already is on record as opposing ocean dumping.)

***A-2499-Smith—Fetal Alcohol Syndrome (FAS).** Establishes a (FAS) education and prevention program in the Department of Health and appropriates \$700,000. **Action Deferred**, pending referral of perinatologists' correspondence received from Doctor Riggs to MSNJ's Committee on Maternal and Child Care for a final report.

***A-2524-Miller—AIDS.** Requires a physician to disclose positive results of AIDS test to patient's spouse. **Conditional Approval**, 1. Physician shall inform patient spouse, if any. 2. An HIV positivity, which has been confirmed, shall be reported to the Department of Health, state of New Jersey and all contacts be notified by the appropriate Division within the Department of Health. 3. Throughout the bill "HTLV III" be changed to "HIV."

A-2597-Colburn—Medicare Information (same as S-2458). A supplemental appropriation to the Department of Health to implement a Medicare telephone information system. **No Action**.

***A-3060-Singer—Nursing Services in State Facilities.** Creates a committee to study the quality of nursing services in state-operated facilities to evaluate what must be done to assure quality nursing services. **No Action**.

***A-3206-Bush—Nursing.** Creates a committee to review the employment practices of state government regarding nurses to recommend methods to assure that high-quality staffs are available. **No Action**.

***A-3736-Duch—Criminal Responsibility.** Provides for the commitment of persons who are acquitted because of mental disease or defect if the defendant is a danger to himself or others. **Approved**.

***A-3738-Girgenti—Orthotists and Prosthetists.** Provides for the licensing and regulation of orthotists and prosthetists through an advisory committee in the Division of Consumer Affairs. Physicians are exempted from the requirements of the act. **Action Deferred**, pending further clarification as to licensing and certification.

A-3791-Girgenti—Allied Health. Requires regulatory agencies that certify or accredit allied health personnel to include instruction in infection prevention and control. **No Action**.

A-3891-Roberts—Mobile Intensive Care. Establishes a mobile intensive care fund. Hospitals would be reimbursed for MICU services. Patients could not be billed directly, but hospitals could bill third-party payors. **Action Deferred**, pending further information from MSNJ's Committee on Emergency Medical Care.

A-3986-Villapiano—Dioxin Research. Creates a special "consortium" to conduct research on dioxin contamination. Appropriates \$2,000,000. **Disapproved**, extensive research needs to be done on the federal level. The amount proposed for a state program is woefully inadequate.

A-3991-Doria—Podiatry. Permits podiatrists to certify physical disability for handicapped parking privileges. **Approved**.

A-4014-Haytaian—Nursing Aides. Provides for nurse aide training programs. **Disapproved**, this bill would fragment a process that already is well addressed without legislation.

A-4045-Colburn—Medicaid. Extends Medicaid coverage to certain pregnant women and children under one year (family income is 185 percent of federal poverty level); children up to five years of age if family income is 100 percent of federal poverty level. **Active Support**.

A-4046-Shusted—Structured Payments. Provides for structured payments in civil actions against health care providers when future damages exceed \$250,000. An annuity contract must be offered to guarantee the future payments. **Active Support**.

A-4142-Kavanaugh—Commissioner of Health. Deletes the current requirement of a medical license to be commissioner of health. Provides that there be a deputy commissioner who is a licensed physician. **Action Deferred**, pending further information from MSNJ's Council on Public Health regarding what other state requirements and experiences have been.

A-4179-Felice—Organ Donations. This bill deletes the requirement in the law that a completed organ donation option certificate be attached to a death certificate in order for the death certificate to be deemed complete. This bill is necessary in order to ensure the prompt handling of the deceased once a death certificate is prepared. **Approved**.

A-4329-Hardwick—Eye Enucleation. Allows eye bank technicians and other medical students to enucleate eyes. **Approved**.

AR-132-Kavanaugh—Uncompensated Care. Creates a task force to study uncompensated care. Does not provide for MSNJ representation. **No Action**.

AR-139-Hardwick—Medicare Catastrophic Coverage. Requests Congress to find means in addition to beneficiary premiums to fund the Medicare Catastrophic Coverage Act of 1988. **No Action**.

*Considered by MSNJ Board of Trustees, April 9, 1989.

The Reference Committee recommended that Supplemental Report #2 be filed.

HOUSE ACTION: Adopted. The report was filed.

Resolution #13

Introduced by: Morris County Medical Society
Subject: Surgical Assistants
Referred to: Reference Committee "D"

Whereas, there is a severe shortage of bedside nursing care which the AMA indicates is approaching a national shortage of 300,000 nurses; and

Whereas, the American Nurses Association maintains a continuing policy to close diploma and licensed practical nursing schools; and

Whereas, the American Organization of Nurse Executives (AONE) opposes efforts by the AMA to substitute registered care technologists to ease the nursing shortage; and

Whereas, the New Jersey Board of Nursing does not accept the concept of Nurse First Assistants; and

Whereas, there is a 50 percent decrease in surgical hospital residencies; and

Whereas, the above situations create a shortage of surgical assistants; now therefore be it

Resolved, that the concept of employing trained, nonphysician surgical assistants for first and second assisting in the operating room under the direct control of the surgeon be endorsed by the Medical Society of New Jersey; and be it further

Resolved, that the Medical Society of New Jersey cause to have the appropriate legislation drawn up for approval by the New Jersey Legislature to authorize surgical assistants.

The overwhelming majority of those present did not favor Resolution #13, as currently proposed. They felt that the Board of Trustees should establish a committee to investigate and make suggestions concerning the specific needs for cardiac technicians to assist cardiac surgeons.

The Reference Committee recommended that Resolution #13 be rejected.

HOUSE ACTION: Resolution #13 was rejected.

Resolution #14

Introduced by: Ocean County Medical Society
Subject: Manpower Organization for Political Action
Referred to: Reference Committee "D"

Whereas, physicians are being increasingly harassed and controlled by an oppressive bureaucracy and have been unable to mount an effective resistance; and

Whereas, individually, physicians are influential and have the capacity to make a positive impact on the legislative process; and

Whereas, there has been no organized body to coordinate and direct purposeful and effective physician response in matters affecting their professional conduct; now therefore be it

Resolved, that the Medical Society of New Jersey set up an infrastructure to: 1) collect and collate demographic data of physicians, their spouses, children of voting age, and employees; 2) maintain a constant flow of legislative information to these groups to heighten their awareness of pertinent matters; and 3) organize a chain of communication to ensure a comprehensive response from the targeted group thereby effectively amplifying the influence of the group as a whole.

There was little support for Resolution #14, as submitted, and there was particular opposition to Item (1) of the resolved. The Reference Committee felt that it is important that each county society be motivated to encourage its members to become a cohesive force in the legislative process.

The Reference Committee recommended that Resolution #14 be rejected.

HOUSE ACTION: The recommendation was not adopted. Resolution #14 was referred to the Board of Trustees.

Resolution #21

Introduced by: Passaic County Medical Society
Subject: New Jersey Ombudsman for the Institutionalized Elderly
Referred to: Reference Committee "D"

Whereas, the ombudsman has determined that he has the legal authority to review the practice of medicine when a person is age 60 or over, is institutionalized in a nursing home or a psychiatric hospital, and has not been currently and legally determined able to make decisions on his/her own about the withdrawal or withholding of life-sustaining medical treatment; and

Whereas, as a result of an investigation by the ombudsman, physicians may be charged with criminal violations of the Mandatory Reporting of Adult Abuse Law for using their medical judgment to prescribe or to omit treatments of these patients; and

Whereas, criminal charges are not covered by medical malpractice insurance; and

Whereas, the threat of criminal prosecution will inevitably distort medical judgment in determining appropriate treatment of these patients and can lead to unwanted, unnecessary, and excessive treatment; now therefore be it

Resolved, that the Medical Society of New Jersey take legislative and legal action to allow physicians in New Jersey to utilize reasonable professional medical judgment without the threat of arbitrary investigation and prosecution by the ombudsman for the institutionalized elderly.

In view of the fact that the current ombudsman has resigned, the Reference Committee felt that Resolution #21 should not be acted upon.

The Reference Committee recommended that Resolution #21 be rejected.

HOUSE ACTION: Resolution #21 was rejected.

Resolution # 22

Introduced by: Passaic County Medical Society
Subject: Registered Care Technologists
Referred to: Reference Committee "D"

Whereas, a registered care technologist (RCT) is a non-nurse bedside caregiver created by the American Medical Association (AMA) as a solution to the shortage in nursing personnel; and

Whereas, the AMA has historically supported the pursuit by nurses of professional status and the independent control of nursing education that is a prerequisite to professionalism; and

Whereas, a RCT would duplicate many of the functions for which people already are being trained within nursing education; and

Whereas, a RCT would be accountable to physicians rather than the nursing hierarchy which would lead to confusion in the bedside care of patients; and

Whereas, the costs for training and compensating a RCT would be built into a hospital's already expensive charges and be paid for by patients; and

Whereas, the nursing profession would be put into a position of competing within the same labor pool against this new non-nursing trade when recruiting; and

Whereas, the New Jersey State Nursing Shortage Study Commission has recommended: an analysis of nurses' compensation in New Jersey; a nursing scholarship/loan cancellation program; and a media campaign to promote nursing as an exciting and rewarding career; but did not recommend the creation of a new non-nursing caregiver; now therefore be it

Resolved, that the Medical Society of New Jersey oppose the creation of registered care technologists on the grounds that a new non-nurse bedside caregiver does not address the fundamental causes of the nursing shortage, but does represent an unwarranted intrusion by medicine into the practice of nursing; and be it further

Resolved, that this position in opposition to registered care technologists be taken to the American Medical Association's House of Delegates by the New Jersey delegation.

The Reference Committee recommended that Resolution #22 be adopted.

HOUSE ACTION: *The recommendation was not adopted. Resolution #22 was postponed indefinitely.*

Committee on Revision of Constitution and Bylaws

JOHN H. LIFLAND, MD, CHAIRMAN

(Reference Committee on Constitution and Bylaws)

PROPOSED AMENDMENTS TO THE BYLAWS

1. *Advisory Committee to the Auxiliary.* The Board of Trustees, upon the recommendation of the Committee on Long-Range Planning and Development and with the concurrence of the Auxiliary, approved the discontinuance of the Advisory Committee to the Auxiliary from the list of standing committees. The function of the Advisory Committee is being accomplished through the Auxiliary's liaison with the Board of Trustees. Both the president and president-elect of the Auxiliary routinely attend the Board of Trustees' meetings, and members of the Auxiliary serve on the Society's councils and committees.

Chapter IX—Administrative Councils and Committees

Section 3—Administrative Councils and Standing Committees

Current

Proposed

(n) Advisory Committee to the Auxiliary

Delete

The Advisory Committee to the Auxiliary shall consist of three (3) members elected by the House of Delegates, and a discretionary number appointed by the President.

The Committee on Revision of Constitution and Bylaws recommends adoption of the Bylaw proposal.

The Reference Committee recommended adoption of the proposed change for deletion of the Advisory Committee to the Auxiliary from the Bylaws.

HOUSE ACTION: Adopted.

2. *Special Assessments.* The action taken by the 1987 House of Delegates to place a \$100 special assessment on each member for public relations purposes has produced controversy regarding what type of enforcement action should be taken. The Committee on Long-Range Planning and Development and the Committee on Revision of Constitution and Bylaws are of the opinion that a special assessment should be resorted to only in the event of a major crisis.

Chapter X—Finance

Section 5—Special Assessments

Current

Proposed

Special assessments other than those necessary to fund the annual budget may be considered by the House of Delegates at any meeting of the House of Delegates, and if adopted by the House, shall become the obligation of all dues-paying members in such forms and amounts as the House shall declare. Unless otherwise stipulated by the House, delinquency in regard to a special assessment shall be treated in the same fashion as delinquency in the annual assessment.

Special assessments other than those necessary to fund the annual budget may be *initiated by the Board of Trustees and presented to the House of Delegates at any meeting of the House. Seventy-five percent (75%) of the delegates present must approve the assessment.*

The Reference Committee recommended the following substitution to Chapter X—Finance, Section 5—Special Assessments:

Proposed

Special assessments other than those necessary to fund the annual budget may be initiated by the Board of Trustees or the House of Delegates at any meeting of the House. *Two-thirds (2/3)* of the delegates present *and voting* must approve the assessment.

The Reference Committee recommended an amendment to this section (*italics indicate amendment*).

HOUSE ACTION: *Adopted as amended by the Reference Committee.*

3. *Emeritus Membership Category.* The Committee noted that the term emeritus is generally associated with an honorary title conferred upon individuals who have retired and have been permitted to hold the rank of their last office, or who have achieved preeminence in their profession. However, the category of emeritus member as used in the Society's Bylaws was initially incorporated to accommodate those physicians who encountered personal tragedy which prevented them from practicing medicine and paying regular dues. The Committee on Revision of Constitution and Bylaws believes there is no honor attached to the emeritus category and therefore it should be eliminated. The Board of Trustees can grant dues exemptions as necessary for financial hardship and/or illness. [Individuals who retire because of age or infirmity would qualify under the exemption authority provided under Chapter X—Finance, Section 1—Annual Assessment (Dues.)]

Chapter 1—Membership

Section 1—Composition

Current

Proposed

(d) Emeritus Members

Delete

Emeritus members shall be physicians who have been members in good standing of a component society and who by reason of age or infirmity have retired from the active practice of medicine; or members of this Society who have been disabled by reason of military service. Nominations shall be submitted by the component societies, and emeritus membership shall be conferred by a majority vote of the House of Delegates. Emeritus members shall have all the privileges of membership except the right to vote and hold office, and their respective component societies shall not be assessed for such members provided they are carried as emeritus members in said component societies. Emeritus members shall not be included in the membership of a component society when computing the number of delegates to which such society is entitled. Active practice shall be determined by policy decision of the Board of Trustees or the House of Delegates.

The Committee on Revision of Constitution and Bylaws recommends adoption of the Bylaw proposal.

The Reference Committee recognized that the word "emeritus" can have different meanings and felt that the term is confusing. The major portion of the discussion at the Reference Committee dealt with the payment of dues.

The Reference Committee recommended adoption of the proposed change for deletion of the emeritus membership category from the Bylaws as of June 1, 1989. Those who are emeritus members as of May 31, 1989, will continue to be considered "emeritus members."

HOUSE ACTION: *Not adopted. This section was referred to the Committee on Revision of Constitution and Bylaws for further study and report.*

4. *Repeal of Age-Related Dues Exemption.* While the Bylaws provide that dues are not levied against any member who has attained the age of 70, the Committee on Long-Range Planning and Development believes that the current policy is not realistic in today's world, since many physicians beyond that age have significant economic resources. The Committee suggested that a dues reduction schedule could be established for physicians over 70.

The Committee on Revision of Constitution and Bylaws considered a formula, suggested by the Committee on Long-Range Planning and Development, which provided for a decrease in dues every year after the age of 71. The dues reduction formula was not approved by the Committee on Revision of Constitution and Bylaws, because it was found to be administratively cumbersome. The Committee believes the formula would place an unnecessary burden upon the component societies.

[This change will remove the dues exemption for physicians that attain age 70 after June 1, 1989. Those that attained age 70 prior to that date would continue to be exempt. Further, it enables the Committee on Finance and Budget, the Board of Trustees, and the House of Delegates to set categories or levels of dues at certain ages without amending the Bylaws. Retirement as such should have no impact on the responsibility to pay dues. Exemptions would continue for financial hardship. Those able to pay but unwilling to do so should not continue in membership.]

The Reference Committee heard considerable testimony about the need for a reduced dues structure for physicians who have retired or who have reached age 70. Several physicians, over age 70, expressed their willingness to pay a fair amount for the services they receive. The Reference Committee believes the Society should follow the AMA guidelines as to dues structure.

Chapter X—Finance

Section 1—Annual ~~Assessment~~ Dues

Current

Proposed

(a) By the first day of January in each year, each component society shall be officially informed of the per capita assessment levied by the House of Delegates. Payment of this assessment shall be forwarded to the Treasurer of this Society not later than five (5) days before the first of March, together with a list of the members for whom such payment is made.

(a) By the first day of January in each year, each component society shall be officially informed of the *dues* levied by the House of Delegates. Payment shall be forwarded to the Treasurer of this Society not later than five (5) days before the first of March, together with a list of the members for whom such payment is made.

In several places, grammatical changes were made whereby the word “dues” was substituted for “per capita assessments.”

The Reference Committee recommended adoption of editorial changes (*italics indicate changes*).

HOUSE ACTION: *Adopted.*

Current

Proposed

(b) Per capita assessments shall apply in the same manner immediately upon the admission or reinstatement of members, except that for a member entering the first year of post-residency practice, the Medical Society of New Jersey dues shall be fifty percent (50%) of regular dues. For a new member admitted after September first of any calendar year, only one-half (1/2) of the regular per capita assessment shall be levied. Every member for

(b) *Dues shall be determined by the House of Delegates at such levels as it deems appropriate at the annual meeting. Dues* shall apply in the same manner immediately upon the admission or reinstatement of members, except that for a member entering the first year of post-residency practice, the Medical Society of New Jersey dues shall be fifty percent (50%) of regular dues. For a new member admitted after September first of any calendar

Current

whom the per capita assessment is paid shall be entitled to receive such publications as may be issued by this Society for its members.

Proposed

year, only one-half (1/2) of the regular per capita assessment shall be levied. Every member for whom the per capita assessment is paid shall be entitled to receive such publications as may be issued by this Society for its members.

The Reference Committee recommended the proposed editorial changes to the Bylaws be adopted:

(b) *Dues shall be determined by the House of Delegates at such levels as it deems appropriate at the annual meeting. Dues shall apply in the same manner immediately upon the admission or reinstatement of members, except that for a member entering the first year of post-residency practice, the Medical Society of New Jersey dues shall be fifty percent (50%) of regular dues. For a new member admitted after September first of any calendar year, only one-half (1/2) of the regular dues shall be levied. Every dues-paying member is entitled to receive such publications as may be issued by this Society for its members.*

HOUSE ACTION: Adopted.

(c) If a member has not paid his annual assessment by June first, his name shall be dropped from the membership rolls.

(c) If a member has not paid his annual *dues* by June first, his name shall be dropped from the membership rolls.

The Reference Committee recommended the proposed editorial change to the Bylaws be adopted (italics indicate change).

HOUSE ACTION: Adopted.

(d) The annual assessment of a component society shall not be less than the per capita assessment of at least ten (10) members, the smallest number to whom a charter may be granted to form a component society.

Delete

The Reference Committee recommended the proposed editorial change to the Bylaws be adopted.

HOUSE ACTION: Adopted.

(e) This assessment shall not be levied against any member in good standing if:

(d) *Dues* shall not be levied against any members in good standing if:

The Reference Committee recommended the proposed editorial change to the Bylaws be adopted (italics indicate change).

HOUSE ACTION: Adopted.

1. He shall have attained the age of seventy (70) years; or

1. He shall have attained the age of seventy (70) years *by June 1, 1989; or*

The Reference Committee recommended the proposed change to the Bylaws be adopted.
HOUSE ACTION: Not adopted. This section remains intact.

Current

2. He is serving in the armed forces of the United States as a draftee, or as a volunteer in times of military conflict; or
3. He is a member emeritus; or
4. The payment of the assessment would be a financial hardship by reason of physical disability or illness. A member also may be excused from payment of the assessment because of financial hardship for other reasons, but these reasons must be set forth annually by the secretary of the member's component society.

Proposed

2. He is serving in the armed forces of the United States as draftees, or as volunteers in times of military conflict; or

Delete

3. The payment of *dues* would be a financial hardship by reason of physical disability or illness. A member also may be excused from payment of *dues* because of financial hardship for other reasons, but these reasons must be set forth annually by the secretary of the member's component society.

The Reference Committee recommended the proposed changes to the Bylaws be adopted.

HOUSE ACTION: *The following section was adopted by the House of Delegates:*

1. He shall have attained the age of seventy (70) years; or
2. They are serving in the armed forces of the United States as draftees, or as volunteers in times of military conflict; or
3. He is a member emeritus; or
4. The payment of *dues* would be a financial hardship by reason of physical disability or illness. A member also may be excused from payment of *dues* because of financial hardship for other reasons, but these reasons must be set forth annually by the secretary of the member's component society.

(e) As of June 1, 1989, the dues structure for all active members shall be:

1. All members under age 70 will pay full dues.
2. Those members over age 70, working more than 20 hours per week, will pay full dues.
3. Those members over age 70, working 1 to 20 hours per week, will pay 50 percent of dues.
4. Those members over age 70, working zero hours, will pay 20 percent of dues.

The Reference Committee recommended the proposed amendment be adopted.

HOUSE ACTION: *Not adopted. Section (e) was referred to the Committee on Revision of Constitution and Bylaws.*

HOUSE ACTION: *Adopted. The report of the Committee on Constitution and Bylaws was adopted as amended.*

Resolution #11

Introduced by: Burlington County Medical Society
Subject: Eligibility for MSNJ Emeritus Membership
Referred to: Reference Committee on Constitution and Bylaws

Whereas, nominees for emeritus membership in the Medical Society of New Jersey must be members in good standing of a component society and who, by reason of age or infirmity, have retired from the active practice of medicine; or members who have been disabled by reason of military service; and

Whereas, the Medical Society of New Jersey recently announced it to be unreasonable to use age as a reason for doctors below the age of 65 years to be nominated for emeritus membership; and

Whereas, retirement trends for physicians in New Jersey and elsewhere in the United States are changing; now therefore be it

Resolved, that physicians who have fulfilled 20 years of active membership in the Medical Society of New Jersey and who retire from the active practice of medicine be eligible for nomination for emeritus membership in the Medical Society of New Jersey regardless of age.

In view of the previous action recommended by the Reference Committee, there will be no further additions to emeritus membership, except for those already in that category as of the close of this meeting.

The Reference Committee recommended that Resolution #11 be rejected.

HOUSE ACTION: *The recommendation of the Reference Committee was not adopted. Resolution #11 was referred to the Committee on Revision of Constitution and Bylaws.*

Senior Citizens Task Force

A. RALPH KRISTELLER, MD, CHAIRMAN

The Senior Citizens Task Force, established at the 1986 Annual Meeting of the House of Delegates, continues in its dual purpose of 1) creating a forum which affords an opportunity for the elderly to express to physicians their concerns regarding the delivery of health care, and 2) creating an understanding of how current and proposed regulations impact on the delivery of health care to the elderly.

During the past year, speakers were invited to address the Task Force on a myriad of topics relevant to the delivery of quality health care. Topics and speakers included: "Nursing Shortage," Barbara Wright MA, RN, executive director of New Jersey State Nurses Association; "Pennsylvania Blue Cross/Blue Shield," Everett Bryant, vice-president of Government Business, Kim Dieter, manager of Medicare Professional Services of Pennsylvania Blue Cross/Blue Shield, and Maurice Hartmann, regional administrator for Health Care Finance Administration; "Medicare Toll-Free Line," Edward Peloquin, executive director, Central Jersey Health Planning Council; and "Registered Care Technologist and HR 4455," John Kasper, CAE, American Medical Association, Division of Medical Society Relations.

On October 12, 1988, the Task Force conducted its third annual forum entitled, "Who Lives? Who Dies? Who Decides? The Right To Life and The Right To Die." One hundred twenty attendees heard the keynote speaker Paul W. Armstrong, JD, and participated in two panel discussions: "The Right To Life" and "The Right To Die."

The next forum is planned for October 25, 1989. Gubernatorial candidates will be asked to address senior health care issues.

The Task Force expressed its concern with increased denial of home health care claims in letters to the New Jersey Congressional Delegation and requested the Board of Trustees of the Medical Society of New Jersey to withhold support on proposed legislation which would have granted monies for the creation of a Medicare Toll-Free Information Service. It was felt that a number of agencies already was offering this service.

The Task Force requested the Board of Trustees of the Medical Society of New Jersey to have Pennsylvania Blue Cross/Blue Shield provide 800 phone numbers for beneficiaries as well as an 800 phone number for physicians.

In December, physician members of the Task Force expressed their extreme dismay regarding an "anti-physician" press release by an organization entitled United Senior Action (USA). Many of the officers of USA served on the Senior Task Force.

The Board of Trustees also took exception to the press release stating that "certain seniors involved in the Task Force and Forum have dealt in a duplicitous fashion with the Society." Consequently, the Board of Trustees directed that the Task Force be restructured and senior representatives be nominated by county medical societies.

The first reorganizational meeting of the Task Force occurred on April 12, 1989.

Resolution on Surgical Assistants

At its meeting on Sunday, April 9, 1989, the Board of Trustees considered reports from the Council on Medical Services and the Hospital Medical Staff Section pertaining to Resolution #13 (Surgical Assistants).

The following excerpt from the minutes of the Board of Trustees meeting is supplied for the information of the House of Delegates:

At the February 19, 1989, meeting of the Board of Trustees, Doctor Ames L. Filippone presented a Resolution on surgical assistants, which the Morris County Medical Society plans to introduce to the 1989 House of Delegates.

Resolved, that the concept of employing trained, nonphysician surgical assistants for first and second assisting in the operating room under the direct control of the surgeon be endorsed by the Medical Society of New Jersey; and be it further

Resolved, that the Medical Society of New Jersey cause to have the appropriate legislation drawn up for approval by the New Jersey Legislature to authorize surgical assistants.

Before taking a position on the Resolution, the Board requested input from the Council on Medical Services and the Hospital Medical Staff Section.

The Resolution on surgical assistants was reviewed by the Hospital Medical Staff Section at their meeting on March 2, 1989. Doctor Ames L. Filippone, representing the Morris County Medical Society and the New Jersey Chapter of the American College of Surgeons, addressed the meeting. Following an extensive question-and-answer session, the Section voted to advise the Board of Trustees that the preponderance of opinion was not in favor of the Resolution.

At the meeting of the Council on Medical Services, it was pointed out that State Board of Medical Examiners' regulations require first assistants for major surgery in New Jersey to be physicians, a requirement obviously in conflict with the stated purpose of the Resolution. A member of the Council on Medical Services suggested calling the individuals in question "surgical technicians" instead of "surgical assistants" as a possible means of resolving the problem.

The Morris County Medical Society and the New Jersey Chapter of the American College of Surgeons have pointed out that surgical assistants must take a national examination drawn up under the auspices of the American College of Surgeons and the AMA, and that they function technically in the operating room on the level of a second-year resident.

Mr. Maressa commented that legislation previously proposed in support of surgical assistants would give them the right to prescribe drugs and perform other medical services outside the operating room.

If the services performed by surgical assistants are limited to technical aid and confined to the operating room, the State Board of Medical Examiners could review a list of functions and determine whether such functions could be performed under direct physician supervision. A favorable decision by the State Board would obviate the need to pursue legislation on surgical assistants.

The Board of Trustees concluded that this issue should be decided by the House of Delegates, and deferred action on the Resolution.

Report of the Nominating Committee

Offices Filled by Election

Office	Term	Nominee and County
President-Elect	1 year	Douglas M. Costabile, MD, Union
1st Vice-President	1 year	Joseph A. Riggs, MD, Camden
2nd Vice-President	1 year	William E. Ryan, MD, Mercer
Secretary	3 years	Bernard Robins, MD, Essex
Treasurer	3 years	Gerald H. Rozan, MD, Passaic

Trustees:

1st District	3 years	Joel S. Cherashore, MD, Essex
2nd District	*1 year	Philip J. Jasper, MD, Passaic
2nd District	3 years	G. Gerson Grodberg, MD, Bergen
4th District	**2 years	Angelo S. Agro, MD, Camden
5th District	3 years	John J. Pastore, MD, Cumberland

*Elected to fill the vacancy created by Dr. Rozan's election as Treasurer

**Elected to the unexpired term of George L. Triebenbacher, MD, Ocean County

Judicial Councilors:

1st District	**1 year	Anita Falla, MD, Essex
2nd District	3 years	Alden B. Hall, MD, Sussex
5th District	3 years	Paul H. Steel, MD, Atlantic

**Elected to vacancy created by resignation of Edward M. Coe, MD, Union County

AMA Delegates:

2 years	Joseph A. Riggs, MD, Camden
2 years	Robert H. Stackpole, MD, Union
2 years	Frank Y. Watson, MD, Essex

AMA Alternate Delegates:

*1 year	Carl Restivo, Jr, MD, Hudson
*1 year	Bernard Robins, MD, Essex
**2 years	Paul J. Hirsch, MD, Somerset
2 years	Harry M. Carnes, MD, Camden
2 years	William E. Ryan, MD, Mercer
2 years	Donald J. Holtzman, MD, Union
2 years	Robert J. Weierman, MD, Essex

*Elected to the unexpired terms of Joseph A. Riggs, MD, and Robert H. Stackpole, MD, who were elected AMA Delegates

**Elected to the vacancy created by the death of George L. Triebenbacher, MD

Administrative Councils:

Legislation:

5th District	2 years	L. Willis Allen, MD, Cumberland
6th Member	2 years	Jerome A. Molitor, MD, Union

Medical Services:

5th District	2 years	Narasimhaloo Venugopal, MD, Cumberland
6th Member	2 years	Charles L. Cuniff, MD, Hudson

Mental Health:

3rd District	2 years	Douglas H. Robinson, MD, Mercer
5th District	*1 year	Terry A. Johnston, MD, Atlantic
6th Member	2 years	William R. Nadel, MD, Union

*Elected to the vacancy created by the death of N.J. George, MD, Cumberland County

Public Health:

5th District	2 years	Gerald S. Packman, MD, Cumberland
6th Member	2 years	Glenn P. Lambert, MD, Hunterdon

Public Relations:

2nd District	2 years	G. Jerry Falcone, MD, Hudson
5th District	2 years	Kelly M. Reid, MD, Atlantic

Standing Committees:

Annual Meeting	2 years	Thomas J. Connolly, Jr, MD, Hudson
Finance and Budget	2 years	Matis A. Fermaglich, MD, Bergen
Medical Education	2 years	Sherman Garrison, MD, Cumberland
Membership Services	2 years	John J. Sprowls, MD, Union
Publication	2 years	Clement H. Kreider, Jr, MD, Monmouth

PRESERVATION PLAN ON IT



Planning on restoring a house, saving a landmark,
reviving your neighborhood?

No matter what your plans, gain a wealth of
experience and help preserve our historic and
architectural heritage. Join the National Trust for
Historic Preservation and support preservation
efforts in your community.

Make preservation a blueprint for the future.

Write:



National Trust for Historic Preservation
Department PA
1785 Massachusetts Ave., N.W.
Washington, D.C. 20036



CAPITOL COMMENTARY

MEDICAL WASTE PROGRAM

To operate a medical waste tracking system, the Department of Environmental Protection (DEP), wants to put a solid gold Rolls Royce on the road. The motor's running and DEP is ready to drive its new limousine out of the showroom—primarily at the physicians' expense.

The Department's medical waste regulations, which will cost physicians, dentists, veterinarians, and others \$528.50 a year to register as "small generators," were adopted on an emergency basis by Governor Tom Kean on June 26, 1989. Although the emergency regulations are effective for only 60 days, the Department has set into motion the process which will lead to their permanent adoption.

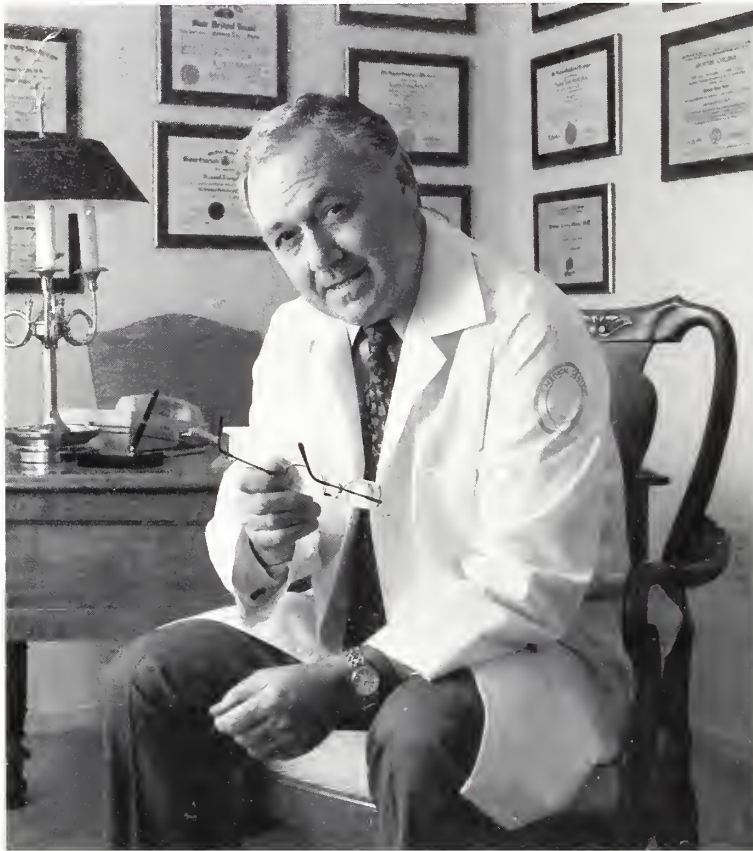
The Society is fighting this extravagant program on two fronts: legislative and administrative. Responding to complaints, the Assembly Committee on Solid Waste Management conducted a public hearing on the proposed rates in early July, shortly after they were made public. Stanley R. Lane, MD, chairman of MSNJ's Committee on Environmental Health, called on legislators to direct the DEP to cut back on manpower, use a system of spot checks instead of annual audits, and provide for lower registration fees. On the administrative front, the Society, in mid-July, was gearing up to testify at DEP's August 1 public hearing.

To say that the medical waste rules were adopted quickly is an understatement. Only three weeks prior to the Governor's action, we were told that the regulations still were being drafted, but that we could expect a registration fee of around \$100 to \$150.

That much hasn't changed—the DEP has yet to grant official recognition to any of the medical waste companies already doing business in New Jersey—but at least now we know we are in for a battle to trim the size and scope of an enforcement program which would: create 92 new state jobs, including 68 in Environmental Protection and another 24 in Health; cost over \$6 million annually, with \$4.7 million of that amount coming from the proposed \$528.50 registration fee levied on small generators (less than 300 pounds per year); charge large generators (over 1,000 pounds per year) only \$317 more than a small generator; and conduct annual audits of generators, with 4 hours set aside for physicians, dentists, and other small generators—but only 12 hours for hospitals.

Even worse, the registration fee for generators may be just the tip of the iceberg. The DEP plans to extract astronomical fees from medical waste haulers; a small company with only three vans will be charged \$5,500 a year, and this cost of doing business certainly will be passed back to the customer. As one hauler told us, "Pennsylvania charged me a one time fee of \$200, and I'm following the federal guidelines to haul medical waste to an EPA-approved incinerator in South Carolina. New Jersey won't even process a temporary permit for me, and now they want thousands of dollars. I can't understand it. All this will do is create hostility in my customers." □

**“A big insurance company
that’s really listening to me?”**



**I don’t
believe it.”**



PROFESSIONAL LIABILITY

REASONABLE LITIGATION ASSISTANCE

The Appellate Division of the Superior Court, our State's second highest court, determined that a treating physician has a legal duty to render reasonably required litigation assistance to his patients (*Spaulding versus Hussain*, 229 N.J. Super. 430 [App. Div. 1988]). In *Spaulding*, the plaintiff sued his neurologist, who had treated him for serious injuries suffered when he fell into a pit at a scrap metal yard. The plaintiff had filed a suit against the owner of the yard, and the defendant, his physician, apparently agreed that as long as he had adequate notice he willingly would appear at trial. However, despite adequate advance notice, the defendant failed to appear and because of this, the plaintiff's attorney was forced to accept what he considered an inadequate settlement offer. The plaintiff then filed suit, charging that his physician had intentionally breached his agreement to testify, and had breached an alleged duty, as a treating physician, to testify on his behalf, if necessary. At the trial, a judgment in the amount of \$87,500 plus interest was entered against the defendant.

On appeal, the Appellate Division agreed that an award of damages against the physician was warranted. In reaching that decision, the court stated that, as a matter of principle, "a treating physician has a duty to render reasonably required litigation assistance to his patient" (229 N.J. Super. at 440). The court went on to state that in the circumstances of this case—where the physician had agreed to testify—it was not required to determine whether a physician must testify in court no matter what the circumstances. But, the court stated: "Clearly, a physician who tells his patient from the outset that he will not testify is not thereby absolved from rendering other litigation assistance, including the rendering of reports, consultation with counsel and forensic witnesses, and the like. By the same token, we are not prepared to say that a physician who does not make such an early disclaimer has no choice but to testify. He may, in the particular circumstances, be able to fulfill his duty to render litigation assistance in like manner or by submitting to videotaped depositions (229 N.J. Super. at 440-441)."

The court went on to note "the ongoing tensions between the medical and legal professions in respect of required physician testimony" (229 N.J. Super. at 441). "Doctors generally do not want to come to court, and personal-injury plaintiffs cannot try their cases without them." Therefore, stated the court, trial judges generally are flexible in accommodating the schedules of testifying physicians. But, the court emphasized, physicians who have treated individuals suing in court may not simply ignore the needs of litigation. The court stated: "However far the litigation duty may extend at its outer limits, this much at least is clear—a treating physician is not at liberty to ignore with impunity the basic obligation of rendering a reasonable modicum of litigation assistance. Nor is he free, without compelling professional justification, to renege on a promise, reasonably and detrimentally relied upon by his patient, to render specific litigation assistance."

Henceforth, physicians whose patients file personal injury cases will be held to the standards articulated in *Spaulding versus Hussain*. Thus, physicians should be careful to clarify, at the time they are requested to render litigation assistance, the arrangement, both financial and otherwise, which is expected between the physician and his patient (*Joseph M. Gorrell, Esq., Brach, Eichler, Rosenberg, Silver, Bernstein, Hammer and Gladstone, of Roseland, NJ*)

BLOOD DONOR MUST ANSWER QUESTIONS

The Colorado Supreme Court has ruled that a blood donor must answer written questions as part of the discovery process in an AIDS case. The Court fashioned a specific procedure to be followed in this case in order to protect the identity and the privacy of the blood donor who had tested positive for HIV antibodies after donating blood.

A patient was admitted to a hospital for a postpartum hemorrhage. An emergency hysterectomy was performed and, in the course of treatment, the patient received four units of whole blood and two units of packed red blood cells. One of the six units of blood was contaminated with the AIDS virus. About a year after the blood transfusion, one of the blood donors returned to the blood bank to donate blood again. The donor's blood tested positive for HIV virus. The blood bank notified the hospital that had received the earlier blood donation, and the hospital notified the physician who treated the patient who received the blood. As a result, the patient was tested and was found to be HIV positive. She then filed against the blood bank for negligence in screening and testing the blood. The patient sought discovery of the identity of the six people who donated the blood she used, as well as all records relating to the blood donations. The blood bank refused, but by agreement provided copies of the six donor cards with identifying information deleted, but with medical history and health information intact. The patient demanded disclosure of the donors' identity and complete records. The trial court ordered disclosure under "confidential" arrangements. The blood bank took the issue to the Supreme Court.

Because the ELISA test was not yet in use, the blood bank's established screening and testing procedure consisted of the donor's medical history, determined from 30 yes/no questions on the donor's card, and its written guidelines, which were applied to unsatisfactory answers to any of the medical history questions. The guidelines required a technician to interview the patient with reference to any unsatisfactory responses on the donor card. The responses of the donor in the interview determined if the individual was acceptable for blood donation. The card of the donor of the AIDS-infected blood indicates that the answers to four questions were unsatisfactory, but that the technician authorized the donation after questioning the donor. The patient contends that the information on the donor card is not sufficient to determine if the blood bank followed its own guidelines. The blood bank contends that the identity of donors is confidential and privileged and may not be disclosed.

The Supreme Court held that a Colorado statute, specifically prohibiting disclosure of the identity of an individual who has tested positive for HIV, was enacted several months after this lawsuit was filed and applies only prospectively to suits filed after its enactment. The Court further held that it must balance the patient's right to discovery of all information necessary to permit the patient to pursue her claim, against the competing rights of the donor to privacy and the blood bank's public policy interest in maintaining an adequate supply of volunteer blood.

The Court ruled that the patient should not be denied the opportunity for discovery directed at events that transpired when the infected blood was donated.

The Court then tailored a limited procedure for discovery based on written questions to be propounded to the donor through the clerk of the Court, who will keep the identity of the donor in strict confidence and delete any matter in the answers to the questions that may reveal the identity of the donor.

A dissenting opinion criticized the Court's unwillingness to use the statutory protection for those who have tested positive for HIV. The dissenting opinion suggests that the confidentiality provisions of the law focus on the date of disclosure, not on the date of collection of the information or the date of the lawsuit. The dissent also criticizes the Court's balancing of the interests by strongly supporting society's need to have an adequate blood supply available.

COMMENTS: BLOOD DONORS

This case seems to indicate that, despite a universal agreement on the need to protect the AIDS patient's identity, when another person has been injured, that protection somehow is circumvented. Perhaps a more carefully drafted statute would have protected the AIDS patient. But, to be sure, the Court did not construe the statute, so we really do not know the extent of the protection, if any, that this statute will provide to AIDS patients. The only focus in this case was on the time when the statute became effective. Perhaps it will require yet another case to decide the extent of the statutory protection available to AIDS patients in Colorado.

It is reassuring to see that society's interest in an adequate blood supply was recognized by the Court, even though that interest was subordinated to the rights of the individual claimant. Certainly the devastation caused by the transmission of the HIV virus is an overriding factor in all AIDS cases. Let us hope that no community is ever forced to be without an adequate supply of blood.

On the positive side, the Court went to extraordinary lengths to protect the AIDS patient's privacy and identity while granting discovery rights to the claimant. The Court's sensitivity to the AIDS patient's position is to be applauded. The dissent doubts the effectiveness of the protection provided by the Court and certainly many questions remain as to implementation of the order and the effectiveness of the discovery rights granted.

Of course, this case involving blood donors is far from over. The lawyers obviously face problems as to the use and admissibility of the information discovered. Questions of evidence may bring this case back to the Colorado Supreme Court for further rulings before the ultimate issue of the blood bank's liability is decided. (*William B. Smith, JD, senior attorney, Health Law Division, AMA. Reprinted with permission from The Citation, American Medical Association, Volume 58, February 15, 1989.*)

LETTERS AND QUESTIONS

Please address all questions and comments to A. Ronald Rouse, Director of Special Projects, MSNJ, Two Princess Road, Lawrenceville, NJ 08648. The Department of Liability Control, under the direction of James E. George, MD, JD, welcomes reader inquiries concerning all aspects of professional liability.

Your own medicine.



The Exchange is the *only* company providing professional liability insurance that is endorsed and sponsored by the Medical Society of New Jersey.

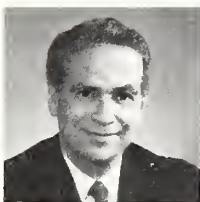
The Exchange was founded in 1976 by the Society itself because New Jersey physicians urgently needed a secure, stable professional liability program. The commercial carriers had abandoned the State. The Exchange is governed by its insured physicians because a doctor-owned company can best take care of medical professionals' needs.

That's why the Exchange's membership includes more than 7,500 practicing physicians and surgeons in New Jersey... a taste of their own medicine.



**Medical Inter-Insurance
Exchange of New Jersey**

2 PRINCESS ROAD, LAWRENCEVILLE, NEW JERSEY 08648
800-257-6288 609-896-2404



PRESIDENT'S PAGE

BOARD MEETINGS

In my Address to the House of Delegates at our Annual Meeting, I outlined some of the goals and priorities of your Medical Society. Now, after three months, I would like to report to you about our progress, in working toward these goals.

In discussing the fragmentation of our profession, and the need for unity of the medical profession in this state, I said:

I intend to take additional specific steps to increase participation by our members who are active in other medical organizations, and to increase their involvement in our Medical Society—their Medical Society. I hope that these steps will lead to larger steps in the future. The Medical Society of New Jersey is and shall be the organization for effective medical unity in this state.

Since that time, I have met with representatives of the Hospital Medical Staff Section and with representatives of the medical specialty societies in New Jersey. I have invited each of these groups to designate a single representative, to sit at the Board of Trustees' table, at our monthly meetings. Dr. Harold Yood, chairman of the Governing Council of the Hospital Medical Staff Section, will represent that group; and Dr. George Neumaier, president-elect of the Dermatological Society of New Jersey and president-elect of the New Jersey Association of Medical Specialty Societies, will represent the specialty societies. They will not be "voting members" of the Board of Trustees; but, I believe that their presence, and their participation in our deliberations, will strengthen our medical community. (The county societies, of course, will continue to be represented by the elected members of the Board of Trustees.)

LEADERSHIP DEVELOPMENT

In my speech to the House of Delegates at the 1989 Annual Meeting, I also discussed the importance of leadership, and leadership development. I spoke of "expanding the opportunities for leadership (and) appointing a Task Force on Leadership to help identify, encourage, and develop leadership abilities."

I believe that we have indeed expanded the leadership, with new chairmen and vice-chairmen of several key committees. I have formed a Task Force on Leadership, with Dr. Palma Formica as chairman, and Dr. John Iacuzzo as vice-chairman. We have scheduled a "President's Conference" for the leadership of the medical community in New Jersey, to be held on November 15, 1989. The presidents, presidents-elect, and executive directors of our county medical societies, state specialty societies, hospital medical staffs, as well as members of the Board of Trustees and of the AMA Delegation, will be invited to attend this important meeting.

STRATEGIC PLANNING

I also stated, "Strategic planning is the most important challenge for a large successful organization. We must look carefully and critically at

ourselves, to see where we have been, and where we have been going to prepare ourselves to anticipate and meet the challenges and opportunities of the future."

Our Long-Range Planning Committee has initiated this process. It will culminate in a Long-Range Planning Retreat for the Board of Trustees scheduled to be held in March 1990. As I promised, I will report about this at our next Annual Meeting.

LEGISLATIVE WORKSHOP

I emphasized the importance of our activities in the formulation of public policy, and stated, "We will add to our efforts a legislative workshop involving members of our Legislature, members of the Board of Trustees and other members of the Medical Society."

This legislative workshop is scheduled to be held on October 4, 1989.

During the campaign for the recent New Jersey primary elections, the leadership of your Medical Society met with the major candidates, to discuss our concerns and interests. We plan to meet again with the candidates in the general election, to continue this dialogue.

CONTINUING WORK

These are a few of the areas in which I believe we have made progress toward our goals. We will continue to work in these and other areas. In my meetings with many of you, I continue to hear similar requests for continued efforts with legislation; the need for improved communication with members; and an ongoing public relations effort. Your priorities are our priorities. □



EDITOR'S DESK

EVEN IF IT HURTS

Mrs. Jones appeared in the office, as scheduled, for her periodic breast examination. She was an attractive, middle-aged, intelligent schoolteacher whose benign breast problems had improved during our professional relationship.

"How have you been since your last visit, Mrs. Jones? Have any other problems developed?"

"Well, I have noticed some irregularity of bowel movements and some rectal bleeding, similar to the problem I had a couple of years ago."

"As I recall, the complete workup then showed minor hemorrhoidal disease that settled down. Also, I seem to remember that you were under considerable stress then; are you having similar problems now?"

"As a matter of fact, I'm worried about my daughter, who is distraught at the loss of a friend."

"By the way, did you ever have that consultation for the headaches you told me about at your last visit?"

"I sort of wish I hadn't, but I did see the neurologist in the city."

"And?"

"He told me my neurologic examination and other tests were normal, but I had suffered a minor brain infarction. He also said that some of his British colleagues thought this could or would lead to Alzheimer's disease, but he did not agree. But he also wanted to see me periodically for testing."

"And?"

"The bowel problem developed the next day. I'm really worried."

In past generations, tuberculosis and syphilis were the twin scourges of civilization; to receive one of these diagnoses was to receive a potential death sentence. Somewhat later, a diagnosis of diabetes prompted some to dive out of upper story windows; this was, of course, in the pre-insulin days.

More recently, cancer in all its manifestations has replaced tuberculosis, syphilis, and diabetes as the nemesis of mankind. The "Big C" became the one to fear; it continues to paralyze the will and to create despair, despite the oncologic advances of the times.

But the "Big C" now has been joined by the two "Big A's"—AIDS and Alzheimer's disease—as harbingers of illness and death and, thus, dreadful to consider.

Alzheimer's disease and other causes of dementia are described most clearly and succinctly by Melvin Konner, MD, in *The New York Times* article on June 25, 1989, entitled "The Loss of Self." In this article, Dr. Konner gives his answer to the question of how long he wanted to live.

"My answer, without hesitation, is that I do not want to outlive my brain. The inevitable insults of the body's decay are bad enough. The least we have a right to expect from old age is mental life. . . ." How simple, and yet profound, a statement.

How cruel and thoughtless was the statement made by the neurologist to Mrs. Jones, a lovely woman of superior intellect and mentation, by even hinting at the chance she might develop Alzheimer's disease, a yet quite incurable, devastating in its sociologic and psychological associations and devoid of hope.

In this issue of *NEW JERSEY MEDICINE* is the tale of another mental illness, entitled "The Gift of Life." It could well have been named, "The Gift of Hope." Although its message is not the antithesis of the one given to Mrs. Jones, it certainly represents a more positive approach to illness—one that does not remove hope, while life and hope remain. It should not be necessary to always tell the truth—the whole truth—even though it hurts, especially when that truth is tinged by more than a little doubt. And how it can hurt!

DR. SCOTT IS HONORED

A member of our Camden County component, W. Eric Scott, MD, was honored with the 1989 Shubin/Weil Award for Excellence by the Society of Critical Care Medicine. Dr. Scott is chief, Department of Anesthesia, and head, Division of Critical Care Medicine at Cooper Hospital/University Medical Center. Dr. Scott has been instrumental in developing Cooper's well-known critical care service devoted to the care of the critically ill patient.



He has worked with the New Jersey State Department of Health to bring recognition to the service of critical care medicine and is admired by his colleagues and students.

MEMBERSHIP DIRECTORY

The *Membership Directory* for the Medical Society of New Jersey is available. All members of the Society have received a copy. For additional copies, send \$65 plus \$3.90 sales tax (except for tax-exempt companies) to Mrs. Joyce Guest, MSNJ, Two Princess Road, Lawrenceville, NJ 08648. If you need additional information, please call 609/896-1766.

SKIN CANCER IN NEW JERSEY

Our special May 1989 issue on skin cancer in New Jersey now is available. This full color issue costs \$6.50 and must be prepaid. As guest editor, Christopher M. Papa, MD, wrote, "Teach the ways to recognize the early warning signs of cancer. Help the patient look and feel better, whether through the use of topical tretinoin sunscreens, or prompt surgical removal of early cancers. The patients will love you for it." Send your check or money order to *NEW JERSEY MEDICINE*, Two Princess Road, Lawrenceville, NJ 08648.

CME IN NEW JERSEY

This September, *NEW JERSEY MEDICINE* will be presenting a special issue on continuing medical education. The purpose of this publication will be to highlight various aspects of continuing medical education as it pertains to New Jersey practitioners. Topics to be included are education and computers, groups that influence CME in New Jersey, and innovations and future trends in the field. The guest editors will be Alan J. Lippman, MD, and James Thorpe, MD. □



BOOK REVIEWS

CHOLESTEROL AND CHILDREN

Robert E. Kowalski. New York, NY, Harper & Row, Publishers, 1988. Although the subtitle on the cover, "A Parent's Guide To Giving Children a Future Free of Heart Disease," perhaps is overly ambitious, we have a volume addressed to the public which contains a large amount of useful information about the origins of cardiovascular atherosclerotic disease and about methods, principally dietary, for reducing morbidity. The author is a writer who, afflicted with vascular disease, learned that his only son had hypercholesterolemia, and launched into a crusade first for his family and then for the public at large. The contents of the book consist of warnings about the nature of the problem, an explanation of pathogenesis, and then extended descriptions, including practical steps to alter a family's nutritional program, of how parents can prevent future problems for their children. There are many lists of what to do, some recipes for cooking, descriptions of how to shop, and how to bring the children into the program as a part of the action. The greatest drawback of this book is its length—302 pages. I do not think many families, except those convinced of dire need, will spend the time needed to learn what the book has to teach, let alone to carry out the program. The style of writing is suitable for the public, but the mass of detail may be too much. Yet, I would not say that there is any portion which I would excise. The topic is a major one. For those families with a history of hypercholesterolemia, or with a family record of early heart attacks or strokes, this can be a very useful book. Physicians should not hesitate to recommend it. □ Avrum L. Katcher, MD

FUNDAMENTALS OF SKELETAL RADIOLOGY

Clyde A. Helms, MD. Philadelphia, PA, W.B. Saunders Company, 1989. This is an unusual and interesting book dealing with skeletal radiology. The book consists of seven sections, with the appendix containing lists of differential diagnoses. The first section, "Unnecessary Examination," is a very unique approach and extremely important in the practical care of patients; I do not agree completely with the author's assessment of myelogram versus computed tomography (CT) without the benefits of magnetic resonance imaging (MRI) in the workup of lumbar disc disease. Another section, "Do Not Touch Lesions," provides useful and practical information. Even with widespread CT application and recent MR introduction in the evaluation of skeletal pathology, the basics imbedded in plain film radiology cannot be overemphasized. The author has done an excellent job in this respect, with emphasis on pattern analysis and differential diagnosis. I found this book to be very relaxing to read and highly informative. I recommend this book for medical students, interns, residents, and practicing physicians. Regular exposure always is useful in understanding the basics. □ S. Howard Lee, MD

SPINAL CORD DYSFUNCTION

L.S. Illis (ed). Oxford, Oxford University Press, 1988. This is a collection of 13 papers by various authors based on a workshop held by the International Spinal Research Trust. Because the most effective therapy must be provided within a few hours of spinal cord injury, the clinician must

first "devise a workable and uniform classification of severity." The "classification and assessment must be based, however, on pathophysiology."

The collection is divided into three sections, addressing structure and function, functional changes, clinical assessment of spinal cord injury, and physiologic assessment of spinal cord function. The topics covered include experimental models of injury, pathologic changes, clinical evaluation of the various cord functions, somatosensory-evoked potentials and related electrophysiologic studies, pharmacologic changes, and recent work on neuroplasticity and regeneration potential. Especially strong are the papers on the radiology of cord injury and neurophysiologic evaluation of the patient. The latter includes a basis for motor and sensory scoring with a plea for development of a standardized protocol.

As usual with many-authored compendia, there are gaps, overlaps, and varying styles. The book neither attempts nor accomplishes saturating coverage of the vast literature of cord injury. Neither does it resolve any of the many therapeutic controversies, and the reader familiar with the field easily will find statements or inferences with which to quibble.

Therapy intentionally is not emphasized, but the book provides an updated and reasonably complete scientific and clinical substrate on which various therapies reasonably may be predicated. Thus, it should be valuable to residents in emergency medicine, neurology, neurosurgery, orthopedics, and physiatry. It comprises a succinct review for experienced practitioners. □ Clement H. Kreider, Jr, MD

SURGEON. VIEW FROM BEHIND THE MASK

Richard S. Weeder, MD. New York, NY, Contemporary Books, 1988. This short and easily read book describes the interpersonal side of a former surgeon's career. The book is organized from the standpoint of the practicing community surgeon and reviews typical and atypical experiences encountered in a busy surgical practice. Dr. Weeder's career choice clearly was influenced by his childhood, and an unyielding paternal encouragement to pursue the practice of general surgery. His decision to leave the practice of surgery and to enter an undefined career path, took place following the death of his father.

The book is organized into 14 chapters which highlight clinical events as vignettes in the life of a patient and his interaction with this surgeon. The emphasis is on the emotional aspect of surgical disease, and chronicles its effects on both patient and doctor. The reader is brought into the mind of the practitioner as he reveals basic emotions which many have felt but rarely verbalized. The events described and the diseases discussed are those which would be encountered by a general surgical practitioner in a suburban community. Patient outcomes are not discussed since the emphasis is on emotional interaction. Weeder describes many of the challenges of practice, including the patient with atypical chest pain, seen by many other practitioners, but found to have a surgically curable problem. He shares the emotional impact of such tragic illnesses as fatal burn, paraplegia following cervical fracture, and brain death following motor vehicle accidents.

This book provides an insight into the human side of the surgical practitioner: an aspect which infrequently is shared. The vignettes from his practice draw upon a wealth of personal experiences which illustrate the emotional demands of complicated diagnostic issues, stressful therapeutic decisions, and difficult clinical situations. The reader effectively shares the feelings of a surgeon. □ Frank T. Padberg, Jr, MD



LETTERS & VIEWPOINTS

PEER REVIEW

In "The Importance of Documentation in Peer Review (96:185-186, 1989)," Dr. David Kingsley reveals that the government hardly has any residual faith in the integrity of physicians. Held captive (sometimes for ransom) by PRO, we now are compelled to make the job of our captors easier via documentation stipulated by PRO.

The examples Dr. Kingsley gives are trite. The first patient had no documentation of an EKG and was called to the carpet only to explain that the EKG had been done on preadmission testing. Exuding largess, PRO approved the case, but not before getting a copy of the EKG to see that the doctor was not lying. Now, let us suppose for the record, that the doctor had documented that the EKG had been done but there had been a slip up at PAT and it had not been done. PRO would not have flagged the case because the documentation was complete.

In the next case, the doctor failed to write down that he had instructed the patient in the proper use of coumadin. When he assured PRO that he had done so verbally, he was exonerated. Are we that all bad? I should think that licensure and accreditation are signals of professional integrity. Why the presumption of guilt, unless something is documented? Why must decent people like Dr. Kingsley implement (and subsist on) a system that holds his colleagues in such low esteem or that demands written attestation of primary and secondary diagnoses? Has the medical profession fallen to such depths that it is believed we hospitalize patients at whim, and treat at whimsy?

Professional relationships are fundamentally built on trust and faith. If that cannot be bred in the bones of physicians, if it does not exist intrinsically, as we enter a profession that has a large missionary component, then there is nothing in the profession that can be fixed by PRO. After all, PRO doctors are no better and perhaps worse than their captives. They are paper doctors treating paper, and there is no blood in the veins of paper. □ Charles Harris, MD

PRO OF NEW JERSEY

To no one's surprise, I trust, I am in agreement with much of Dr. Harris's letter. Like him, I resent the presumption of guilt implied in some of the requisite documentation referred to; however, in the litigious times in which we live, it is not clear to me how any physician can fail to adequately justify and document his clinical decisions. In view of the magnitude and frequency of recent malpractice awards against physicians in this country, reliance on "integrity, trust, and faith" in a court of law is naive at best. I daresay the provision of documentation would serve the busy practicing physician well. Does Dr. Harris similarly balk at providing documentation in filing his income tax return as to exemptions or expenses? Does he not carefully review the documentation on a hotel bill before he pays for services rendered, meals eaten, or other charges incurred? Since the United States government pays for over 40 percent of the cost of medical care, it is not entirely unreasonable for them to require documentation in paying those bills.

Interestingly, Dr. Harris appears less uncomfortable with chart attestation with its implications that physicians might game the system for economic enhancement ("code creep"). Further, he makes no mention of the computerized physician tracking system to be installed this summer by UNISYS at the cost of \$15.9 million. This system, "The National Practitioner Data Bank," the final contribution of Dr. Bowen to organized medicine, faithfully will record any and all suits and licensure actions entered against a physician regardless of merit or outcome. This will remain with the physician as long as he remains in practice and will follow him from state to state, should he move. Hospitals and insurance carriers will be required to consult this file before awarding or renewing privileges or insurance, respectively, on an annual basis, for of course, a user fee. I doubt if the legal profession or other interested parties will fail to gain ready access to this information. If Dr. Arnold Relman's numbers as published in the *New England Journal of Medicine* are correct, in that there are approximately 20,000 incompetent or impaired physicians in this country, I wonder whether as a percentage of the total or in absolute numbers, that that number requires a national computer bank as compared to other professional groups: elected officials, Wall Street entrepreneurs, or attorneys. American physicians traditionally are held in high esteem by the public as manifest by the periodic surveys published in the press; politicians and attorneys generally are at the bottom of this list. I respectfully would submit that our current woes reflect a degree of professional envy as well as the economics of the times; the current tasks required of The PRO are a symptom of our loss of autonomy and not its etiology.

Finally, a few corrections. PRO doctors are real doctors treating real patients since nonpracticing physicians are barred, by law, from the review process. Documentation is not stipulated by The PRO but by federal law. Regarding the example of the absent EKG as mentioned by Dr. Harris, that case might well have been reviewed by chance alone regardless of the physician's or anyone else's documentation. The examples provided are indeed trite; most of the sins of omission or commission are just that—trite and careless.

As to Dr. Harris's final remarks, if he is a "captive" then we are all captives of the same process. "Paper physicians" notwithstanding, Dr. Harris cordially is invited to participate in the peer review process and so evaluate the vascular systems of its members. □ David I. Kingsley, MD, President, The PRO of New Jersey, Inc.

LUNG CANCER LIMITED RESECTIONS

The article by Wetstein and Brenner purports to show that wedge or segmental excisions for stage I lung cancer are as effective as more extensive lobectomy or pneumonectomy for short-term disease control.¹ This has been shown previously.^{2,5} We agree that a conservative resection, when technically feasible, with conservation of maximum lung tissue, is a worthy goal in lung cancer surgery. It is my opinion, however, that the study conducted by Wetstein and Brenner does not illustrate these principles validly.

First, the authors divided the sample into two groups, those patients who underwent a "two-stage" procedure consisting of a wedge resection followed by a lobectomy, and a second group comprised of patients who underwent the limited resection only. The first group consisted of 22 consecutive patients treated during a six-month period in 1984 and a second group of 9 consecutive patients treated during a two-year period immediately thereafter. The first group of patients was comprised of

patients who, by functional evaluation, were capable of undergoing lobectomy or pneumonectomy. The second group consisted only of patients who were deemed unsuitable for the more extensive resection. Because of failure to randomize and stratify these groups, I do not believe that they are comparable for analytical purposes and, therefore, the author's conclusion as to the acceptability of limited resections cannot be justified. Whereas it may be desirable in patients with limited pulmonary reserve to do as minimal a resection as possible, in order to prove equivalency, the two groups must be comparable and this does not appear to be the case in this study.

Second, it is not clear how the pulmonary function evaluation influenced the decision for surgery in the group of patients undergoing lobectomy. What happened to patients whose pulmonary function would not allow the more extensive resections?

Third, patient number seven in the "phase I" group, with small cell carcinoma, should have been excluded from this study. Patients with small cell carcinoma have a very poor prognosis following resection alone and, whereas there may be a role for surgery in selected patients, the natural history is sufficiently different so that these patients should not be included in an analysis of those with nonsmall cell carcinoma.⁶

Fourth, there are some discrepancies and misleading information in the reporting of the data relating to complications and to survival. For example, in the enumeration of complications, the overall morbidity for the patients undergoing limited resections is given as 11 in absolute numbers. This does not make sense, since these complications seem to have occurred in only one patient. In addition, the Table pertaining to survival does not indicate the duration of survival as is customary to do in studies dealing with this type of information. Other discrepancies and misinformation abound, but will not be enumerated.

Fifth, it is stated that of the 22 patients undergoing complete lobectomy, 3 patients had "bilateral" lesions and therefore underwent median sternotomy. I do not understand how patients with bilateral lesions can be considered to have stage I disease.

The author's conclusion that segmentectomy or wedge resection may decrease operative morbidity and mortality is not supported by the data.

The premier issue in lung cancer today is not the extent of surgical resection in those patients deemed to be operable, but what adjuvant treatments may be beneficial, in addition to surgery, to provide greater rates of cure, since the majority of patients whose disease is not controlled by resection succumb to disseminated metastatic disease. Protocols utilizing combined modality treatment employing chemotherapy and radiotherapy now are receiving a great deal of attention.⁷⁻¹⁰ □ Alan J. Lippman, MD (References are available upon request.)

LUNG RESECTION: AUTHOR RESPONSE

I would like to thank Dr. Lippman for his interest in our study and his few insightful comments. Most importantly, he agrees with our conclusion: that a conservative lung resection for lung cancer is an appropriate procedure and a "worthy goal in lung cancer surgery." Unfortunately, he has concerns about our study design.

Initially, Dr. Lippman is confused since he implies that the phase I study patients were evaluated for six months, while the phase II patients were followed for two years. In fact, phase I and II groups were gathered over

six months and two years, respectively. All patients then were evaluated up until the time our paper was reported, for a maximum of three years. A very important question to be answered with the phase I patients: after the entire lesion was removed by a limited resection, with adequate margins, was there any remaining malignancy in the remaining lung tissue, i.e. lobe? Based on the data generated, we demonstrated that indeed there were no foci of cancer to provoke a recurrence at the primary site. This allowed us to comfortably subject patients with inadequate pulmonary function to potentially curable limited resections (phase II). Moreover, subsequent followup from our phase II group has confirmed this hypothesis and no patients have developed a recurrence at the primary site.

No mention was made of "randomization nor stratification." We did neither of these processes. That is why we employed the term "appears to be" in the concluding paragraph of our manuscript.

Pulmonary function tests (PFTs) influenced the performance of a lobectomy in the following manner. If the PFT criteria for pneumonectomy were not met, and the lobectomy criteria were met, and the patient was a candidate for lobectomy, then a lobectomy was performed. Patients with poorer PFTs were not included in phase I.

As regards patient 7 with small cell carcinoma, he received postoperative adjuvant chemotherapy and prophylactic radiation to the brain. He has continued to do well, and I do not agree that he should be excluded from our study. I continue to recommend surgical resection for solitary coin lesions regardless of histopathology. In the event, however, the lesion is small cell, anaplastic carcinoma, postoperative adjuvant therapy is recommended to the patient.

Dr. Lippman is correct in that only one patient of the phase II group suffered complications. This relates to an 11 percent morbidity. Therefore, there is an error in Table 4: Overall Morbidity of Limited Resections; it should read "1" in absolute numbers and not "11." His comment about "other discrepancies and misinformation abound, but will not be enumerated" is not only nonspecific and incorrect, but offensive, and will not be addressed.

Many patients present with lung lesions that are not malignant. Furthermore, some of these patients present with bilateral solitary lesions. The clinician/surgeon then must determine if these lesions are bilaterally or unilaterally malignant. Median sternotomy uniformly plays an important role in these patients, allowing us to evaluate and manage both chests simultaneously. None of our patients had bilateral lung cancers. Once these patients satisfied the criteria for stage I lung cancer, they were included in the study. Hopefully, this also elucidates his confusion concerning how "patients with bilateral lesions can be considered to have stage I disease."

Finally, unfortunately, our results do not definitively prove that limited lung resections decrease postoperative morbidity and mortality. Until we are able to generate substantial patients and data relating to this problem, we can only repeat that limited resections "may" decrease operative morbidity and mortality. □ Lewis Wetstein, MD

LETTERS TO THE EDITOR

Letters to the editor are welcome. Communications should be sent to *NEW JERSEY MEDICINE*, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

Aortic Balloon Valvuloplasty

SE DO CHA, MD
ANIL G. KOTHARI, MD
RONALD I. WEINER, DO
CONSTANTINE KASHNIKOW, MD
MICHAEL A. WAPPEL, MD
CECELIA ROMAN, DO
VLADIR MARANHÃO, MD

Fifty-eight patients with severe aortic stenosis underwent successful aortic balloon valvuloplasty. The mean aortic valve gradient was reduced from 65 ± 22 to 32 ± 13 mmHg with symptomatic improvement. The procedure is an effective palliative procedure for patients with high surgical risk.

Since the introduction of aortic balloon valvuloplasty by Cribier¹ in 1986, the procedure has been found to be a useful therapeutic intervention in patients with severe aortic stenosis, especially in patients with high surgical risk. From July 1987 to August 1988, a total of 58 patients underwent successful aortic valvuloplasty at Deborah Heart and Lung Center.

CASE REPORT

An 81-year-old white male was admitted for recur-

The authors are affiliated with the Department of Cardiology, Deborah Heart and Lung Center, Browns Mills. Requests for reprints may be addressed to Dr. Cha, Deborah Heart and Lung Center, Browns Mills, NJ 08015.

rent episodes of pulmonary edema. The patient complained of three pillow orthopnea, dyspnea on minimal exertion, and paroxysmal nocturnal dyspnea. Physical examination disclosed distended neck veins and moist rales at both lung fields. There was a grade V/VI ejection systolic murmur at the base, a grade II/VI early diastolic blowing murmur along the left sternal border, and a grade II/VI pansystolic murmur at the apex. Chest roentgenogram revealed left ventricular hypertrophy, congestive heart failure, and calcified aortic valve. Electrocardiogram revealed atrial fibrillation and complete right bundle branch block. Cardiac catheterization disclosed aortic valvular gradient of 86 mmHg, severe pulmonary hypertension, 1+ aortic regurgitation, and 1+ mitral regurgitation. On the night before his

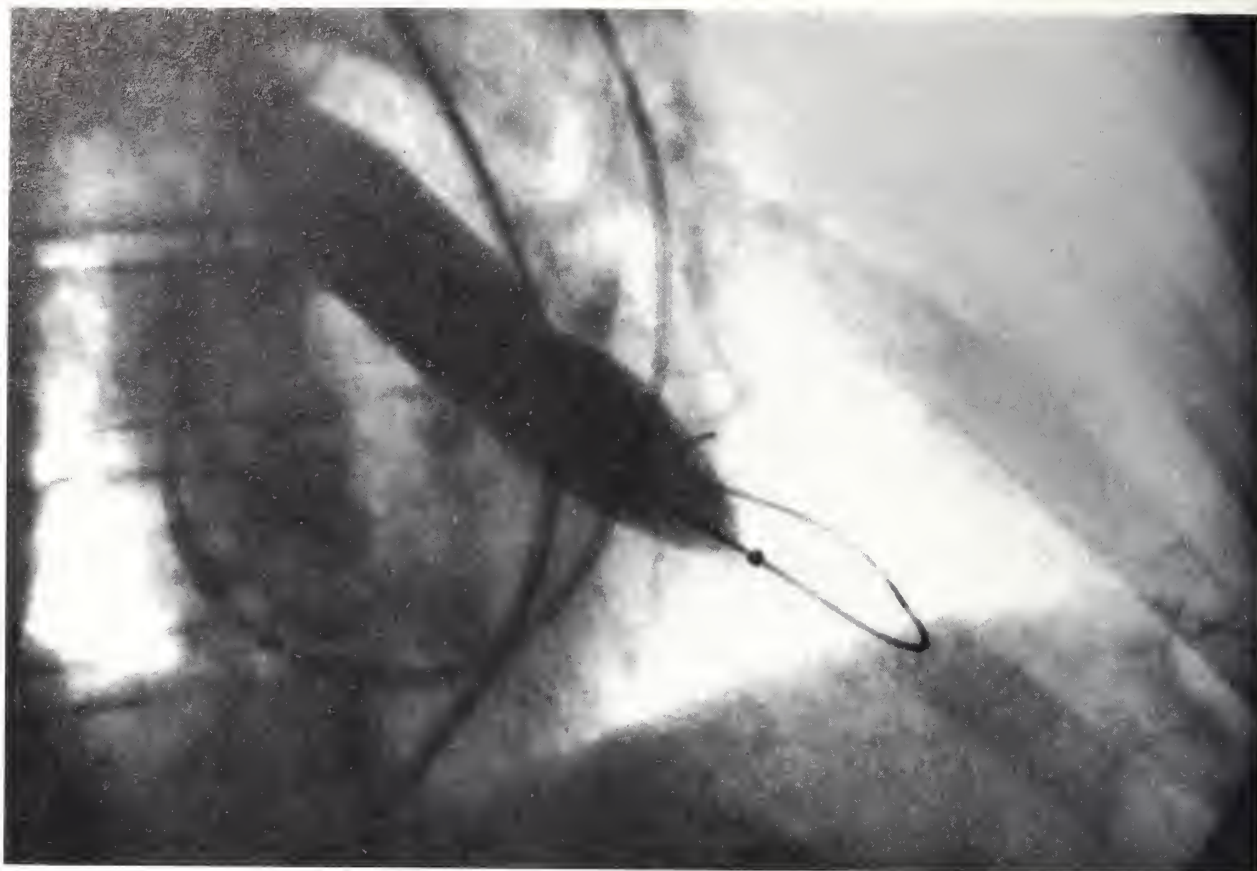


Figure 1. A fully inflated balloon across the aortic valve in RAO projection; the balloon is inflated quickly with the mixture of saline and contrast material and is kept inflated for 5 to 30 seconds depending on blood pressure response.

planned balloon valvuloplasty, the patient developed acute pulmonary edema. Because of the worsening of his condition, an emergency aortic balloon valvuloplasty was performed; there was no complication and the gradient was reduced to 38 mmHg. Our patient improved and was discharged in one week. He remained asymptomatic and resumed usual activities at his six-month followup.

AORTIC BALLOON VALVULOPLASTY

This procedure has not been accepted as a standard treatment for aortic stenosis, and the available balloon catheter has not been approved for aortic or mitral valvuloplasty by the Federal Drug Administration. Thus, the procedure has to be approved by an appropriate hospital committee and the patient has to sign a special informed consent form. The balloon valvuloplasty is offered when the surgical risk is very high or when a patient refuses surgery. The patient is premedicated with a mild sedative and is taken to the cardiac catheterization laboratory. Right heart catheterization is performed for monitoring pressure, temporary pacing, and cardiac output.

Left heart catheterization is performed via the femoral artery. The catheter is placed within the left

ventricle; a 260 cm long guidewire is introduced into the catheter. When the tip of the guidewire is stabilized within the left ventricle, the catheter is replaced by a 12 French sheath and its side port is used for monitoring arterial pressure. Then, an appropriately sized balloon catheter, e.g. 20 mm in diameter, 5. cm in length, is slid over the guidewire and advanced across the aortic valve. The balloon is inflated quickly with the mixture of saline and contrast material (Figure 1) and is kept inflated for 5 to 30 seconds depending on blood pressure response. The balloon inflation can be repeated several times and, if necessary, a larger balloon can be used. If the final aortic valve gradient is acceptable, the procedure is completed with hemodynamic measurement, left ventriculography, and aortography. The patient is transferred to the medical intensive care unit and is observed for 24 hours. Depending on clinical improvement, the patient can be discharged from the hospital the next day and followed every three months.

RESULTS

There were 24 males and 34 females, whose ages ranged from 55 to 92 years (mean age 78 years). Indications for balloon valvuloplasty included: 15 patients who refused surgery and 43 patients with

high surgical risks such as renal failure, severe left ventricular dysfunction, chronic obstructive lung disease, multisystem disease, and elderly age.

The age distribution is shown in Table 1. Thirty-five patients were older than 70 years. The mean aortic valve gradient was reduced from 65 ± 22 mmHg to 32 ± 13 mmHg (mean $\pm$ SD) and the mean aortic valve area was increased from 0.47 ± 0.19 to 0.71 ± 0.29 cm (Figures 2 and 3).²

The highest gradient was 127 mmHg which was reduced to 30 mmHg after balloon valvuloplasty. The lowest gradient was 30 mmHg, reduced to 7 mmHg in a patient with a LV ejection fraction of 9 percent.

Among five patients with no aortic regurgitation, one patient developed 1+ aortic regurgitation after the valvuloplasty. Five patients with 3+ aortic regurgitation revealed no change in the severity of the regurgitation after the procedure and the rest of the patients with 1+ and 2+ regurgitation also showed no change.

In 17 patients, diagnostic catheterization and

valvuloplasty were done at the same setting. Emergency valvuloplasty was performed in 3 patients with acute pulmonary edema.

Complications. As shown in Table 2, seven patients developed near syncope or seizure during the balloon inflation; this resolved without any residual neurological deficit. Three patients exhibited complete AV block with balloon inflation which lasted from a few minutes to a few hours. In our experience, vascular complications were very rare and only one patient (92 years old) required a femoral artery embolectomy. Four patients expired following the procedure. One patient with recurrent respiratory arrest and multisystem disease underwent the procedure as a last option and expired a few hours later, although no apparent complication related to the procedure was found. The second patient expired four days later due to an electrolyte imbalance. The

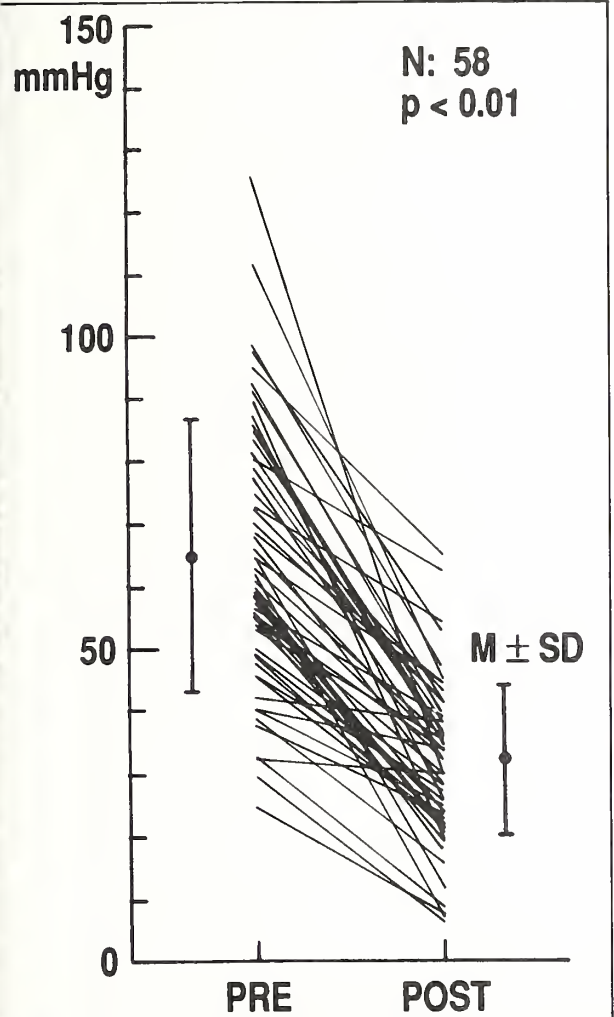


Figure 2. Aortic valve gradient before and after aortic balloon valvuloplasty.

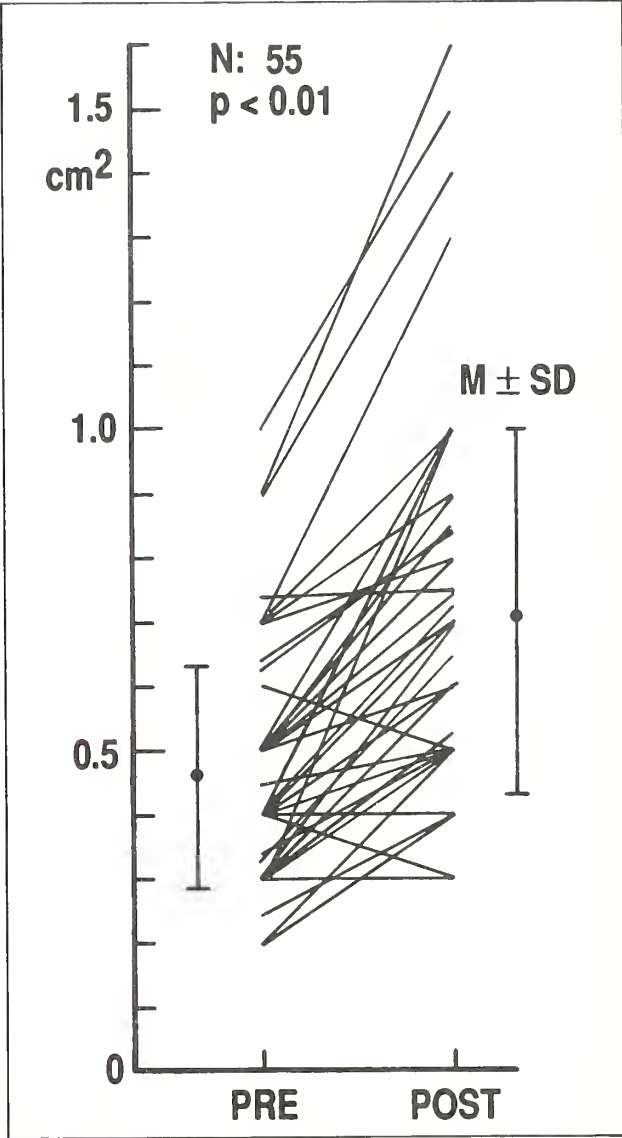


Figure 3. Aortic valve area before and after aortic balloon valvuloplasty.

Table 1. Age distribution.

Ages	Number of Patients
50-59	2
60-69	11
70-79	15
80-89	19
90-92	1
Total	48

Table 2. Complications.

Complication	Number of Patients
Near Syncope or Syncope	7
Complete AV Block	3
Pulmonary Edema	2
LBBB	2
RBBB	1
Junctional Rhythm	1
Femoral Embolectomy	1
Total	17

Table 3. Functional class before and after valvuloplasty.

Before	Functional Class	After
38	IV	1
15	III	2
0	II	38
0	I	11

third patient died suddenly after several months. The fourth patient from our experience expired from a cerebrovascular accident a few months after the procedure.

Clinical status before and after the procedure is shown in Table 3. All patients were in functional class III or IV before the valvuloplasty and the ma-

jority of patients improved to class I or II. The improvement of symptomatology was very dramatic in some patients and several patients with refractory heart failure improved within a few days. The mean hospitalization after the valvuloplasty for all patients was four days.

DISCUSSION

Balloon valvuloplasty is an accepted treatment for pulmonic valvular stenosis^{2,3} but it still is considered to be an experimental procedure for mitral and aortic stenosis, since the long-term result and recurrence rate are unknown. However, the procedure has been reported to be an effective measure to relieve the symptoms⁴ and to improve the clinical condition especially in a patient with high surgical risk or a patient in critical condition.

Although the aortic valve area after the procedure was less than 1 cm² in the majority of patients, all patients improved immediately after the procedure. In some patients, the clinical improvement was so dramatic that they could increase their activities the following day. Also, refractory congestive heart failure from severe aortic stenosis was resolved within a few days. None of our patients developed a cerebrovascular accident in the hospital, although aortic valves of the majority of our patients were heavily calcified. Generally, the degree of aortic regurgitation remained the same.

At the present time, the recurrence rate seems to be high and long-term results are unknown. Therefore, the procedure is not recommended to patients who have a low surgical risk for aortic valve surgery.⁵

Also, the presently available balloon catheter is large and stiff and the vascular complications have been reported to be frequent; it requires further improvement. In our experience, the risk of this procedure is minimal and acceptable considering the high overall risk of the alternatives.

We believe that aortic balloon valvuloplasty is a safe and effective palliative therapy for patients with high surgical risk and for the elderly. It also can be considered in younger patients with poor left ventricular function and severe aortic stenosis to allow subsequent open heart surgery if the clinical condition improves. ■

REFERENCES

1. Cribier A, Saoudi N, Berland J, et al.: Percutaneous transluminal valvuloplasty of acquired aortic stenosis in elderly patients: An alternative to valve replacement? *Lancet* 1:63-67, 1986.
2. Lababidi Z, Wu ZR: Percutaneous balloon pulmonary valvuloplasty. *Am J Cardiol* 52:560-562, 1983.
3. Kan JS, White RI Jr, Mitchell SE, et al.: Percutaneous transluminal balloon valvuloplasty for pulmonic valve stenosis circulation 69:554-560, 1984.
4. Safian RD, Berman AD, Diver DJ, et al.: Balloon aortic valvuloplasty in adult patients with calcific aortic stenosis: Acute and followup studies. *J Am Coll Cardiol* 9:13A, 1987.
5. Block PC: Aortic valvuloplasty—a valid alternative? *N Engl J Med* 319:169-171, 1988.

The Gift of Life

RONNEE H. JACOBSON

young woman suffers from chronic mental illness, characterized by depression and suicidal impulses. With the implementation of lithium therapy, long with her determination, the patient achieves a state of stabilization.

I screamed in anguish as I threw myself across the seat of the moving car; I sought to throw myself onto the pavement. My mother reeched the brakes and pinioned my hands behind my back, as I let out with a volley of curses. My quest for self-destruction had been foiled again.

I was suicidal for over 20 years. It began in my teens and persisted through much of my adult life. I tried various methods, but I guess they were only halfhearted attempts, for here I am, alive to tell my tale.

Where did it all begin? I was the eldest of three girls in a typical suburban middle-class family. My childhood was very happy except for the stressful sibling rivalry between myself and my sisters. I always felt I was being gypped out of love, although there was plenty of love to go around. We learned to dance and to play piano; we took swimming

lessons. These achievements were not enough for me. I craved superiority. I wanted to be the best, especially in school. For a while, I was considered to be the prettiest, most intelligent girl in the school. But all that was destined to change.

In fourth grade, I went to a new school and met a new crowd. My chief competitor, Linnie, was beautiful, popular, and bright. I loved her and hated her. I'd have given all my Barbie dolls for one kind word from Linnie, but she and her clique wouldn't give me the time of day. Instead, they cruelly taunted me for my shyness and clumsiness. I was definitely not popular, but I hoped matters would change, once I reached the magic age of 16.

Sweet 16 and never been much of anything. Academically, I shone, but socially, I was a dud. Linnie was captain of the cheerleaders, president of the National Honor Society, and the most popular girl in the class. The closest I ever came to dating a boy was interviewing the student council president for the high school newspaper. My friends were nice

Requests for reprints can be addressed to Ms. Jacobson, 229 Rose Street, Plainfield, NJ 07060.

FROM THE PATIENT

girls and we tried desperately to pretend that we weren't just a bunch of rejects from the "in crowd."

I was afraid, but I went to college. I bought a whole new wardrobe, from mohair sweaters to herringbone skirts. But, college was a disaster. I was accepted at a highly competitive women's college, and for the first time, I could not make the grade academically. What a source of frustration. I pulled straight C's my freshman year.

Socially, I was much less experienced than the other girls. I was very afraid of men. If a young man so much as put an arm around me, I reacted as if he were about to attack me. About that time, I began falling into the deepest depression of my life. I became convinced I was ugly, stupid, and a bad seed. "Put me away somewhere," I used to scream, "somewhere where people will be safe from me."

Against my better judgment, I returned to school for my sophomore year. I was obsessed with thoughts of disease and death. I submerged myself in books about religious martyrs. One afternoon, while I was strolling through a garden near the campus, I thought I heard God calling to me. The next morning, I broke down in hysterics in a friend's room, sobbing that I was going to hell. Terrified, she placed an emergency call to the school psychiatrist, and they rushed me down to the college infirmary where I proclaimed myself a saint.

I found myself in a posh mental institution, sharing a room with a woman who clucked like a chicken. "Where am I?" I cried. I didn't even know I had a mental breakdown. They placed needles into my arm for electroconvulsive shock therapy, and I was not told what was being done.

Five weeks later, in state of great confusion, I was pronounced "cured" and released from the hospital. Yet, my world had been permanently shattered. The dean requested I withdraw from the University, the source of whatever meager pride I possessed in myself. I wanted to kill myself, but instead I took a job as a clerk typist and studied English literature at night school.

The next year, with a forced optimism, I returned to college. My grades improved, and I picked up a bevy of boyfriends. But, my depression returned and I overdosed and ended up back in the hospital.

Over the next ten years, I drifted in and out of the hospital. I tried to kill myself at least five times. To me, my life was so hopeless, and death was the only solution.

During these unfortunate years, I was graduated from college, attended graduate school, and worked in New York City. My depression got the best of me every time. One night, I ran away from home. I had no idea where I was headed, but I had to escape a "living death." Twelve hours later, I was picked up

wandering aimlessly along the public highway by the police. They directed me to the state mental hospital.

If you have never been a patient in a state mental hospital, you don't know what hell is. Total lack of respect for the dignity and self-worth of the individual is the rule. Kindness, where it can be found, is the exception.

At first, the hospital made me sicker, not better. But, then I looked around me and saw other patients as fellow sufferers who needed a good laugh. I began to joke with some of the patients and to my surprise they responded. I experienced the popularity that had been denied me. I even found a very nice boyfriend. Upon my release, three months later, I was determined never to populate a mental institution again!

This is not to say that recovery has been easy. I worked for five depressing years as a cleaning lady at a nursing home and then as a client at a sheltered workshop where I earned \$.65 an hour.

Soon after I entered into lithium therapy, I acquired a position as an assistant librarian where I was meeting the public. My life really has stabilized. I no longer need extensive psychiatric assistance, and I have become a truly happy person, grateful for the gift of life which enables me to achieve all of my dreams, provided that I believe in myself.

No, my life is not perfect. I am single at an age when my peers have teenage children. I sometimes experience pangs of regret for all those lost years. But, I have hope. I see no impediments to a future marriage. I hope to make my mark as a professional writer and mental health worker.

My story is a frightening one, but it also radiates hope. The pain is only temporary. Today, I look back over my lost youth and wonder how I would handle things today. I hope no one else has to experience first hand what I have been through, but I have learned some very precious truths.

The first is patience. A wise woman once said, "Patient endurance attains all things." The second attribute is faith, be it a religious faith or faith in life. There is a purpose in everything that happens to us. If you believe this, you can accept great suffering. But the last truth is the most important—love of self and love of others. It has been said, "Through love, all things are possible."

CONCLUSION

I face an uncharted future, but armed with these three truths, I know I shall succeed. I am grateful I never succeeded in killing myself. For there is another great truth I found in the abyss of a state mental hospital: the gift of hope; and that truth has never left me. Where there is life, there is hope. ■

Current Concepts in Narcolepsy

JEFFREY NAHMIA, MD
MONROE S. KARETZKY, MD

Narcolepsy, a disabling disorder, has been underdiagnosed. The classic tetrad of symptoms includes sudden sleep attacks, cataplexy, sleep paralysis, and hypnagogic hallucinations. Diagnosis and treatment will restore a normal quality of life.

The crippling effect of excessive daytime somnolence (EDS) and its popularization by Pickwickian tales that trace the drama of obstructive sleep apnea, have contributed profoundly to the development of the study of sleep disorders as a clinical specialty. However, narcolepsy, one of the common causes of EDS and one of the multitude of diagnostic groups described under the category of disorders of excessive somnolence in the Association of Sleep Disorders diagnostic classification, frequently is overlooked.¹ It is a distinct entity, defined in 1926, consisting of frequent daytime naps, sleep

paralysis, and/or cataplexy.² The criteria, currently utilized for establishing the diagnosis, were described in 1957, and include the tetrad of sleep attacks, cataplexy, sleep paralysis, and hypnagogic hallucinations.³ The pathophysiology of the clinical syndrome has been clarified more recently by studies of a dog model⁴ and of nocturnal sleep in patients.⁵ The sleep attacks were shown to represent episodes of rapid eye movement (REM) sleep, and the cataplectic episodes represent periods of "motor inhibition."⁵

Despite the present classification of narcolepsy as a distinct disorder of REM sleep, with strict guidelines for diagnosis and treatment, it remains an orphan disease, briefly touched upon in medical school curricula and frequently misdiagnosed in patients complaining of EDS.

Drs. Nahmias and Karetzky are affiliated with the Newark Beth Israel Sleep Disorders Center, Division of Pulmonary Medicine. Requests for reprints may be addressed to Dr. Nahmias, Newark Beth Israel Medical Center, 201 Lyons Avenue, Newark, NJ 07112.

This review emphasizes the clinical and laboratory characteristics, the high incidence, the early age of onset, and the great potential for success in the treatment of narcolepsy.

SLEEP ATTACKS

Irresistible sleep (narcoleptic) attacks are the most disabling feature of narcolepsy. These "spells" may occur at any time, but have a propensity to appear during boring or monotonous activities, such as driving a vehicle, sitting in a lecture, watching television, or reading. However, these irresistible sleep episodes also occur during emotional and physical exertion, such as sexual intercourse, telephone conversations, or walking.

The sleep attacks can be precipitated by warm temperatures and large meals high in carbohydrates.⁶ Most of the attacks occur with a premonition, producing a soft fall. The sudden onset of fatigue, blurred vision, loss of muscle tone, and hypnagogic hallucinations often precede the actual period of irresistible somnolence. Some attacks, however, occur quite suddenly with no prodromata. The typical patient will report one to eight "naps" per day, with intercurrent "drowsiness," during which time the patient can function reasonably well, but cannot function at peak performance levels.

The presence of EDS also is a reflection of the disturbed nocturnal sleep of narcoleptics^{7,9} with increased awakenings and sleep fragmentation resulting in the complaint of a "poor night's sleep" by approximately 70 percent of patients.

Case Report. A 41-year-old woman was admitted to the Newark Beth Israel Sleep Disorders Center with a chief complaint of EDS and irresistible sleep attacks for the past 25 years. Her sleepiness started in high school where she would fall asleep in classes, causing her grades to suffer. She was chastised for laziness and nicknamed "Sleeping Beauty." She found it difficult to hold down a job due to her daytime somnolence.

When the patient sought medical attention, she was diagnosed as being "depressed" with daytime lethargy and antidepressants were administered. Throughout the ensuing years, her social and marital life deteriorated. She found employment as a secretary with a very understanding boss; she would nap on the commuter train, and take planned naps during her lunch hour and coffee breaks, but still fell asleep while working.

An all-night polysomnogram revealed no evidence of obstructive sleep apnea or nocturnal myoclonus, with a good sleep architecture and sleep efficiency. Her nap studies revealed a mean sleep latency of 4.4 minutes (normal is greater than ten minutes), with

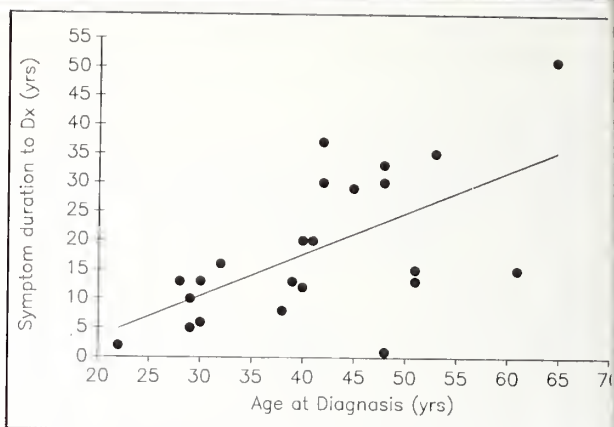


Figure 1. Duration of time from onset of narcoleptic symptoms to actual diagnosis of the narcolepsy syndrome. The mean delay is 18 years.

four sleep onset REM periods. This clinched the diagnosis of narcolepsy and treatment with methylphenidate has resulted in a great improvement in her daytime alertness. The patient currently is dating and is able to function at work.

CATAPLEXY

Cataplexy, the second most disabling symptom of the narcolepsy syndrome, is a sudden decrease or loss of skeletal muscle tone. This may be limited to particular muscle groups or generalized, causing the patient to slump to the floor, paralyzed. In its limited manifestation, the jaw may droop with an inability to speak; patients report only subtle repetitive episodes of neck, arm, or leg weakness. There is full consciousness during the course of this motor inhibition. While sleep paralysis and hypnagogic hallucinations may occur in normal individuals, cataplexy in the awake individual is pathognomonic of narcolepsy. Individuals with narcolepsy rarely present with isolated cataplexy. It has been suggested that a sudden threatening emotional stress, causing the sensation of "knee-buckling," operates along the same neural pathways, but is a more modulated expression of a continuum of inhibitory activity.

Cataplectic attacks usually are triggered by sudden emotional stimuli such as laughter, anger, excitement, fright, or surprise. Patients will report feeling "weak in the knees" with an outburst of laughter or will drop to the ground from the exhilaration of scoring a goal in a sporting event. The attacks can be potentially dangerous for machinists, house painters, and construction workers. Patients who suffer from cataplexy can become "emotional cripples," avoiding laughter, anger, or feelings of exultation.

Polygraphic recordings have demonstrated the flattening of electromyographic potentials and loss

of tendon reflexes accompanying the cataplectic attacks.¹⁰ Eye movements remain intact, as the extraocular muscles are spared. These movements, which also occur during REM sleep, have led to the hypothesis that similar REM sleep motor-inhibitory processes are operative during the cataplectic attack. It recently has been demonstrated that alpha-adrenergic receptors are involved in cataplexy in dogs.¹¹ In addition, narcoleptic patients with hypertension treated with prazosin, a selective alpha-receptor antagonist, have significant worsening of their cataplexy, and patients under previously good control of their cataplexy may deteriorate.¹²

HYPNOGOGIC HALLUCINATIONS

Hypnagogic hallucinations, vivid visual and/or auditory hallucinations which have a frightening character, occur during the sleep attacks or at nocturnal sleep onset. Although specific treatment usually is not needed, occasionally these hallucinations are prominent features of narcolepsy and require suppression. One of our patients presented with the recurrent hallucinations of a rapidly approaching locomotive while she was driving. This resulted in her making last minute swerves of her car "out of the way of the oncoming train" to avoid a collision. Fortunately, she had no motor vehicle accidents, but the consequences could have been disastrous. The hallucinations of narcolepsy also are closely related to the REM dream state.

SLEEP PARALYSIS

The final symptom of the narcolepsy tetrad, sleep paralysis, is a flaccid paralysis which occurs at the onset of sleeping or awakening. It usually lasts a few seconds, and although patients are fully aware of their surroundings, there is an inability to move. Often hallucinatory phenomena will preface an episode of sleep paralysis; they can be terminated by gentle arousal of the patient. One of our patients presented with a chief complaint of sleep paralysis.

Case Report. A 25-year-old female complained of "the inability to move upon awakening in the morning." This paralysis, despite full consciousness, was extremely frightening and lasted between 30 seconds and two minutes. Although not offered as a complaint originally, further questioning revealed the presence of daytime somnolence (she napped daily at lunch and after work) and a few irresistible sleep attacks, although she denied cataplexy. Sleep studies revealed the presence of narcolepsy, and treatments with pemoline and protriptyline have eliminated the sleep paralysis and improved her daytime alertness.

These symptoms are presented in various combinations among narcoleptic patients. The full

tetrad is seen in approximately 10 percent of cases, while the narcolepsy-cataplexy combination is present in approximately 70 percent of cases.¹³

INCIDENCE

There are approximately 100,000 narcoleptics in the United States, with an equal prevalence among males and females. Symptoms usually appear after puberty, with mean age of onset being 18 years.¹⁴ The age of actual diagnosis, unfortunately, is higher, as clearly illustrated by analysis of our patient population (Figure 1). The majority of patients report onset of narcoleptic symptoms prior to age 35 and only rarely after age 40. We have documented new-onset narcolepsy in a 52-year-old Haitian male, precipitated by mercury poisoning. Other rare precipitating factors include head trauma, infectious diseases, and anesthesia.¹⁵ A most important feature of narcolepsy is its familial occurrence. There is a 60-fold increased incidence of narcolepsy in families of affected members. The incidence of affected first-degree relatives of index cases is approximately 30 percent. The histocompatibility locus HLA-DR2 is found in 100 percent of cases,¹⁶⁻¹⁸ whereas other groups of patients with EDS do not have this high incidence of positivity. This is of diagnostic importance, as illustrated by the case of a 17-year-old boy who presented with a disorder of excessive somnolence, but had equivocal symptoms and sleep studies. The negative HLA typing allowed us to exclude narcolepsy and spare him the label of this diagnosis.

PATHOPHYSIOLOGY

There still is controversy over the exact pathophysiologic disturbance in narcolepsy. Several investigators feel narcolepsy is a disturbance of REM sleep.^{5,19-21} Normal REM sleep has a regular cyclical pattern during nocturnal sleep; the first REM period occurs approximately 90 minutes after sleep onset, non-REM sleep occupying the first 90 minutes. The first REM period is the shortest, lasting 15 minutes, with successive REM periods, occurring at 60- to 90-minute intervals, being progressively longer. During REM sleep, the locus coeruleus, located in the mesencephalic tegmentum, triggers an inhibition of muscle activity via descending tracts, causing a flaccid paralysis of the body, sparing the diaphragm and extraocular muscles. REM bursts (phasic REM), originating in the nucleus reticularis pontis caudalis of the pontine tegmentum, stimulate ascending activating systems, producing rapid eye movements, muscle twitches, and irregularity of the autonomic nervous system, e.g. increases in blood pressure and heart rate.¹⁹ It also is during REM sleep that dreams occur.

An abnormal timing of REM sleep, with its intrusion into the awake state is postulated to be the mechanism behind the paroxysmal sleep episodes of narcolepsy. This is supported by the finding of sleep-onset REM (SOREM) periods (Figure 2) during polygraphic recordings in narcoleptics.^{20,21}

The loss of muscle tone during cataplexy or sleep paralysis is postulated to occur by the same descending pathways producing motor inhibition during REM sleep. The patient retains extraocular muscle activity during these episodes, as they do in true REM sleep. Finally, the vivid hypnagogic hallucinations also are felt to be manifestations of the same release of forebrain inhibition which allows dreaming to occur during REM sleep.

The criteria for the diagnosis of narcolepsy include the occurrence of two SOREM periods over four to five structured naps.²² Despite the strong evidence for a disorder of the REM mechanism being responsible for the narcoleptic tetrad, other investigators point to a non-REM disorder as well.²³ They have observed that some of their patients will have non-REM sleep attacks, as well as REM sleep episodes on polysomnographic tracings. So, it now appears that although REM sleep abnormalities play a crucial role in the pathogenesis of narcolepsy, the disorder is not limited to a REM sleep disturbance.

DIAGNOSIS

The diagnosis of narcolepsy depends upon a sleep history consistent with a disorder of excessive day-

time sleepiness usually coupled with one or more the ancillary symptoms. A sleep-wake log kept by the patient at home over a two-week period will help determine if sleep deprivation is the cause of the daytime somnolence. Once the problem of EDS has been confirmed, formal all-night polysomnography should be performed to search for other disorders which may cause daytime somnolence, such as nocturnal myoclonus and sleep apnea, which may be the primary or associated sleep disorders.

A night in a sleep center also will ensure an adequate amount of total sleep time prior to the following days' multiple sleep latency tests (MSLT). The purpose of the MSLT is to quantify sleepiness objectively and identify abnormal sleep patterns during daytime naps, i.e. SOREM. The MSLT consists of a series of four to five naps at two-hour intervals starting between 9:30 A.M. and 10:00 A.M. The patient is given 20 minutes to fall asleep at each nap, and, once asleep, is allowed to nap for 15 minutes. If REM sleep occurs during the 15-minute nap, it is referred to as a SOREM (Figure 2). The mean sleep latency (time taken from lights out to sleep onset) over four to five naps is calculated. A sleep latency of five minutes or less is considered a pathologic level of daytime sleepiness.²² Normal subjects will take between 10 to 15 minutes to fall asleep, with the 5- to 10-minute interval being designated as the grey zone (mild sleepiness).

A combination of two SOREM periods and a mean sleep latency of five minutes or less is strongly

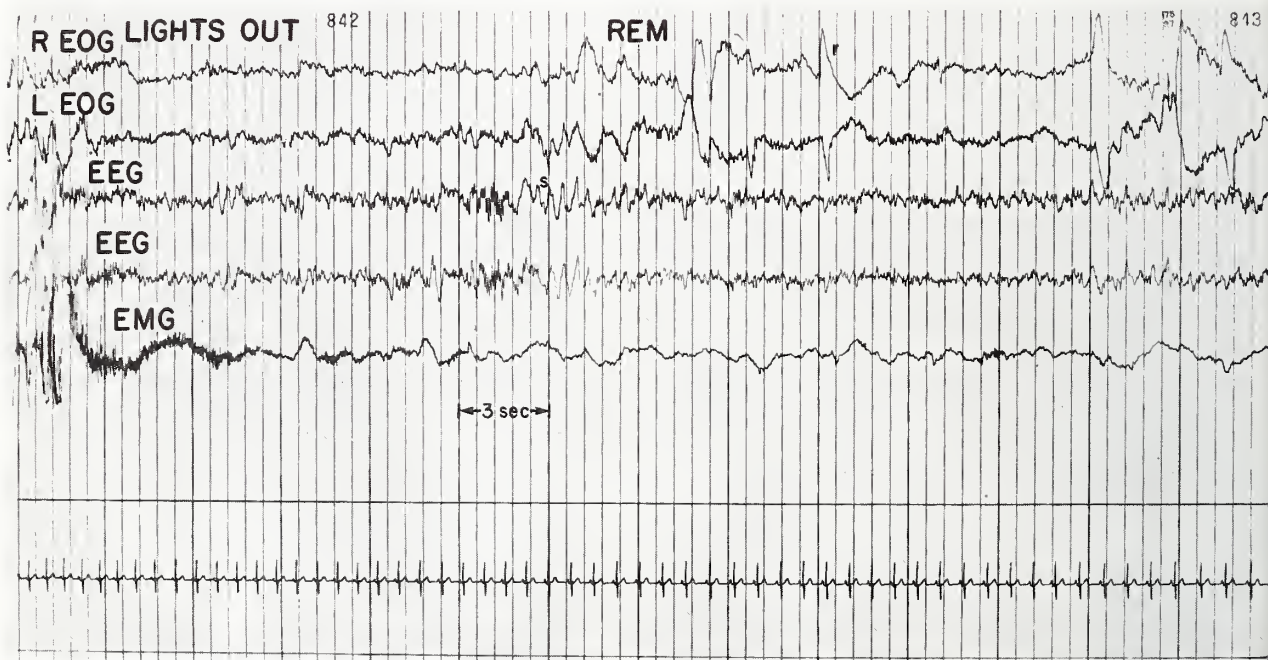


Figure 2. A sleep onset REM period. Forty-second epoch is depicted with awake state at "lights out" and REM sleep occurring 12 seconds after sleep onset. (R EOG, right electro-oculogram; L EOG, left electro-oculogram; EEG, electroencephalogram—2 channels C3/A2, C4/A1; EMG, submental electromyogram). Rapid eye movements (r), low EMG amplitude, and mixed frequency EEG, with sawtooth waves (s) define REM sleep.

evidence supporting a diagnosis of narcolepsy.²⁴ Of course, clinical correlation with the patient's history and previous night's polysomnogram is of utmost importance. The complete MSLT is essential for diagnosis since approximately 50 percent of patients with narcolepsy do not have SOREM periods at night and others may occasionally have a single SOREM onset during MSLT morning naps. At the Newark Beth Israel Sleep Disorders Center, only 54 percent of our narcoleptic patients had a SOREM period during their all-night polysomnogram, but one percent of patients demonstrating SOREM periods at each of the five naps was much greater (Figure 3).

TREATMENT

Excessive Daytime Sleepiness. Typically, treatment first is directed at the most disabling symptoms—daytime somnolence and sleep attacks. The most commonly prescribed drugs are stimulants which include dextroamphetamine (Dexedrin®), methylphenidate (Ritalin®), and pemoline (Cylert®). The amphetamines were among the earliest pharmacologic agents to be used to treat patients with daytime sleepiness.²⁵ In its usual prescribed dosage, dextroamphetamine will prevent fatigue, increase alertness and vigilance, elevate mood, and diminish the number of sleep attacks. It is quite effective in the treatment of narcoleptic attacks, but tolerance often develops. This latter problem, plus the side effects which include headaches,

irritability, hypertension, and, rarely, amphetamine psychosis have relegated the amphetamines to a second-line drug status. Anorexia with weight loss also is frequently reported, but tolerance to the anorexogenic effect develops rapidly. Also, the amphetamines do have high abuse potential, mostly in the non-narcoleptic population, and because of their "street" reputation, often are difficult to procure at pharmacies. One of our patients was unable to find a single pharmacy in Newark who would stock Dexedrin®, forcing him to travel to the suburbs to fill his monthly prescription.

Methylphenidate, a phenylethylamine, is considered the preferred drug for the treatment of narcolepsy by some investigators.^{26,27} Significant side effects are hypertension and irritability. Again, tolerance can develop with prolonged use.

Finally, pemoline, an oxazoline compound chemically similar to the amphetamines, has become a widely prescribed first line drug for the treatment of narcolepsy.^{28,30} Its long half-life and low incidence of cardiovascular side effects has made it a popular alternative. Liver function studies must be performed before and after initiation of therapy, due to pemoline's possible liver toxicity. If liver dysfunction occurs, drug withdrawal usually results in normalization of hepatic enzymes. Headache and nausea, unfortunately, are common patient complaints.³⁰

Treatment of the excessive daytime sleepiness also includes "planned daytime naps."²⁷ These naps

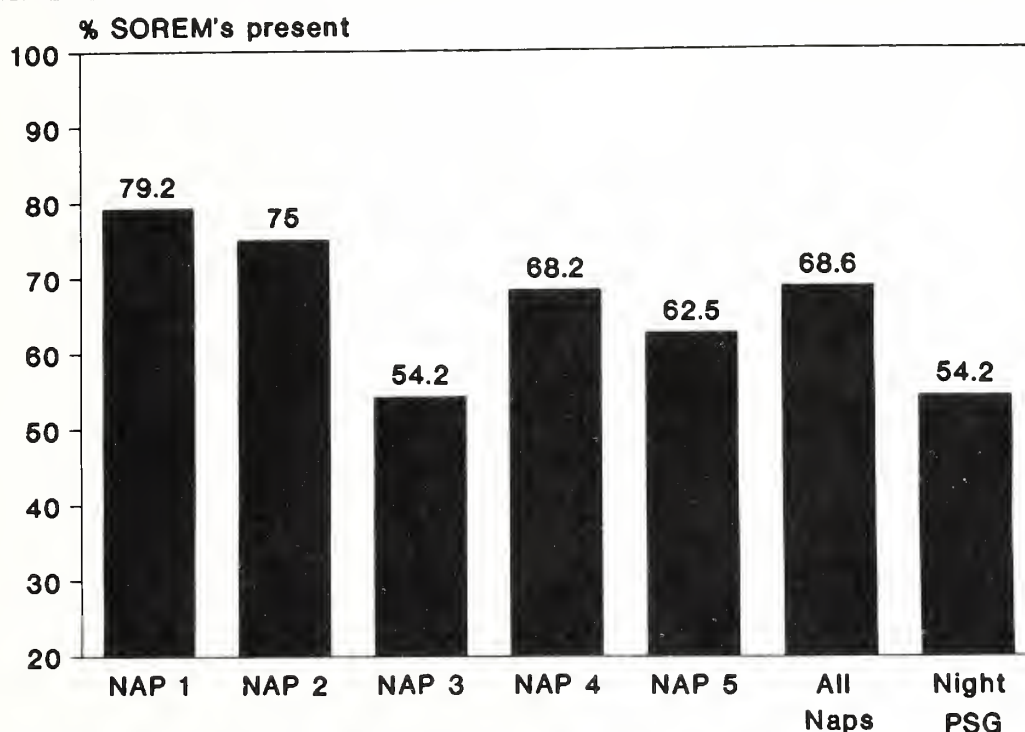


Figure 3. Percent of sleep onset REM periods at each nap and during the all-night polysomnogram in our population.

often are quite refreshing and may allow for a lower dose of the pharmacological stimulant. Naps should be timed to occur at the patient's peak period of sleepiness. Unfortunately, in our hectic society, it often is impractical for a working patient to take a "siesta."

Cataplexy. Imipramine is the most widely used agent for the treatment of cataplexy.⁹ Its rapid onset of action, which is measured in hours as compared to weeks when treating depression, points to a different mechanism of action. As with other tricyclic antidepressants which are used in sleep disorders characterized by EDS, its mechanism of action in narcolepsy is related to its REM suppression properties. Although effective, the side effects often

are bothersome and include dry mouth, urinary retention, and impotency among males. Sedation also can be a problem, so imipramine usually is taken prior to bedtime and is combined with an analeptic. In combination though, hypertension may result.

Other drugs utilized in the treatment of cataplexy include protriptyline, a non-sedating antidepressant which also has been reported to decrease hypersomnia in some patients.³¹ Palpitations are an additional side effect found with protriptyline. Chlorimipramine and desmethylinipramine are other tricyclic antidepressants used. Monoamine oxidase inhibitors have been reported to be successful in cataplexy management,³² but serious side effects have limited their use. ■

REFERENCES

1. Dement W, Guilleminault C: Diagnostic classification of sleep disorders. *Sleep* 2:21-1211, 1979.
2. Adie WJ: Idiopathic narcolepsy: Adesecis sui generis with remarks on the mechanism of sleep. *Brain* 49:257-306, 1926.
3. Yoss RE, Daly DD: Criteria for the diagnosis of the narcoleptic syndrome. *Proc Staff Mayo Clin* 32:320-328, 1957.
4. Mitler M, Boyson B, Cambell L, Dement W: Narcolepsy-cataplexy in a female dog. *Exp Neurol* 45:332-340, 1974.
5. Rechtschaffen A, Wolpert EA, Dement WC, et al.: Nocturnal sleep of narcoleptics. *Electroencephalogr Clin Neurophysiol* 15:599-609, 1963.
6. Ware JC, Karacan I, Dervent A, et al.: A case of narcolepsy with attack precipitated by ingestion of sweet food. *Sleep Res* 8:219, 1979.
7. Zorick F, Roehr T, Wittig R, et al.: Sleep wake abnormalities in narcolepsy. *Sleep* 9:189-193, 1986.
8. Roth B: *Narcolepsy and Hypersomnia*. Basel, S. Karger, 1980, pp. 1-310.
9. Zarcone V: Narcolepsy. *N Engl J Med* 288:1156-1166, 1973.
10. Rechtschaffen A, Dement W: Studies on the relation of narcolepsy, cataplexy and sleep with low voltage random EEG activity. *Res Publ Assoc Res Nerv Ment Dis* 45:488-505, 1967.
11. Mignot E, Guilleminault C, Bowersox S, et al.: Effect of alpha-1-adrenoreceptors with prazosin in canine narcolepsy. *Brain Res* 444:184-188, 1988.
12. Guilleminault C, Mignot E, Aldrich M, et al.: Prazosin contraindicated in patients with narcolepsy. *Lancet* 2:511, 1988.
13. Bowling G, Richards NG: Diagnosis and treatment of the narcolepsy syndrome. Analysis of 75 case records. *Cleve Clin Quart* 28:38-45, 1961.
14. Sours JA: Narcolepsy and other disturbances in the sleep-waking rhythm: A study of 115 cases with review of the literature. *J Nerv Ment Dis* 137:525-542, 1963.
15. Parkes JD, Yenton A, Struther G, et al.: Narcolepsy and cataplexy clinical features treatment and cerebrospinal fluid findings. *Q J Med* 43:525-536, 1974.
16. Honda Y, Juji T, Matsuki K, et al.: HLA-DR2 and DW2 in narcolepsy and in other disorders of excessive somnolence with cataplexy. *Sleep* 9:133-142, 1986.
17. Billiard M, Signalet J, Besset A, Cadilhac J: HLA-DR2 and narcolepsy. *Sleep* 9:149-152, 1986.
18. Langdon N, Welsh K, Van Dam, et al.: Genetic markers in narcolepsy. *Lancet* 2:1178-1180, 1984.
19. Kales A, Vela-Bueno A, Kales J: Sleep disorder Sleep apnea and narcolepsy. *Ann Intern Med* 106:434-441, 1987.
20. Mitchell SA, Dement WC: Narcolepsy syndrome Antecedent, contiguous and concomitant nocturnal sleep disordering and deprivation. *Psychophysiology* 4:398-401, 1968.
21. Rechtschaffen A, Wolpert EA, Dement WC, et al: Nocturnal sleep of narcoleptic patients. *Electroencephalogr Clin Neurophysiol* 15:599-609, 1983.
22. Carskadan MA, Dement WC, Mitler MM, et al: Guidelines for the multiple sleep latency test (MSLT): A standard measure of sleepiness. *Sleep* 9:519-523, 1986.
23. Roth B, Bruhava S, Lehovskiy M: REM sleep and NREM sleep in narcolepsy and hypersomnia. *Electroencephalogr Clin Neurophysiol* 20:176-182, 1969.
24. Richardson GS, Carskadan MA, Flagg W, et al: Excessive daytime sleepiness in man. Multiple sleep latency measurements in narcoleptic and control subjects. *Electroencephalogr Clin Neurophysiol* 45:621-677, 1978.
25. Yoss RE: On the treatment of narcolepsy. *Med Clin North Am* 52:781-787, 1968.
26. Daly DD, Yoss RE: Narcolepsy in, Nagnus O Lorentz D, De Hass M (eds): *The Epilepsies: Handbook of Clinical Neurology, Volume 15*. Amsterdam, North Holland Publishing Co., 1974, pp. 836-852.
27. Dement WC, Baird WP: Narcolepsy: Case and treatment. American Narcolepsy Association, 1977.
28. Honda Y, Hishikawa Y: A long-term treatment of narcolepsy and excessive daytime sleepiness with pemoline. *Curr Ther Res* 27:429-441, 1980.
29. Honda Y, Hishikawa Y: Effectiveness of pemoline in narcolepsy. *Sleep Res* 8:192, 1979.
30. Mitler M, Shafor R, Hafdukavich R, et al.: Treatment of narcolepsy: Objective studies on methamphetamine, pemoline, and protriptyline. *Sleep Res* 9:260-264, 1986.
31. Schmidt HS, Clarke RW, Hyman PR: Protriptyline An effective agent in the treatment of the narcolepsy cataplexy syndrome and hypersomnia. *Am J Psychiatry* 134:183-185, 1977.
32. Wyatt RJ, Fram DH, Buchbinder R, Snyder F: Treatment of intractable narcolepsy with a monoamine oxidase inhibitor. *N Engl J Med* 285:987-991, 1971.

Impaired Bone Marrow in AIDS

KUMUDINI U. MEHTA, MD
PEDRO GASCON, MD, PhD
NIZAR TANNIR, MD
JOSEPH LOMBARDO, MD, PhD
STANLEY J. ROBBOY, MD

Fifty bone marrows from patients with AIDS were studied to identify the abnormalities related to marrow failure. Prominent reticulin fibrosis and increased atypical megakaryocytes were the major changes associated with the aberrant hematopoietic microenvironment.

Acquired immunodeficiency syndrome (AIDS), caused by the group of retroviruses classified as human immunodeficiency viruses (HIV), is characterized by a severe impairment of cellular immune function in an individual who has no other known causes of immune suppression. The effect in immune function clinically is manifested by the development of opportunistic infections and/or unusual malignant neoplasms.

Drs. Mehta, Lombardo and Robboy are affiliated with the Department of Pathology and Drs. Gascon and Tannir are affiliated with the Department of Medicine, UMDNJ-New Jersey Medical School, Newark. Requests for reprints may be addressed to Dr. Mehta, associate director of hematology, UMDNJ-New Jersey Medical School, Newark, NJ 07103-2757.

Patients with AIDS commonly present clinically with various peripheral cytopenias, a leukoerythroblastic blood picture, and a "dry" bone marrow tap. The bone marrows of these patients have shown abnormalities, including the presence of atypical lymphohistiocytic infiltrates, increased plasma cells, eosinophils and megakaryocytes, abnormal distributions of fat, tuberculous granulomas, and reticulin fibrosis.¹⁻⁷

This report is a retrospective study conducted to classify and quantify bone marrow alterations in patients with AIDS at UMDNJ-New Jersey Medical School/University Hospital, Newark.

MATERIALS AND METHODS

We examined bone marrow biopsies from 50 pa-

Histological Changes Present in Bone Marrow Biopsies of 50 AIDS Patients

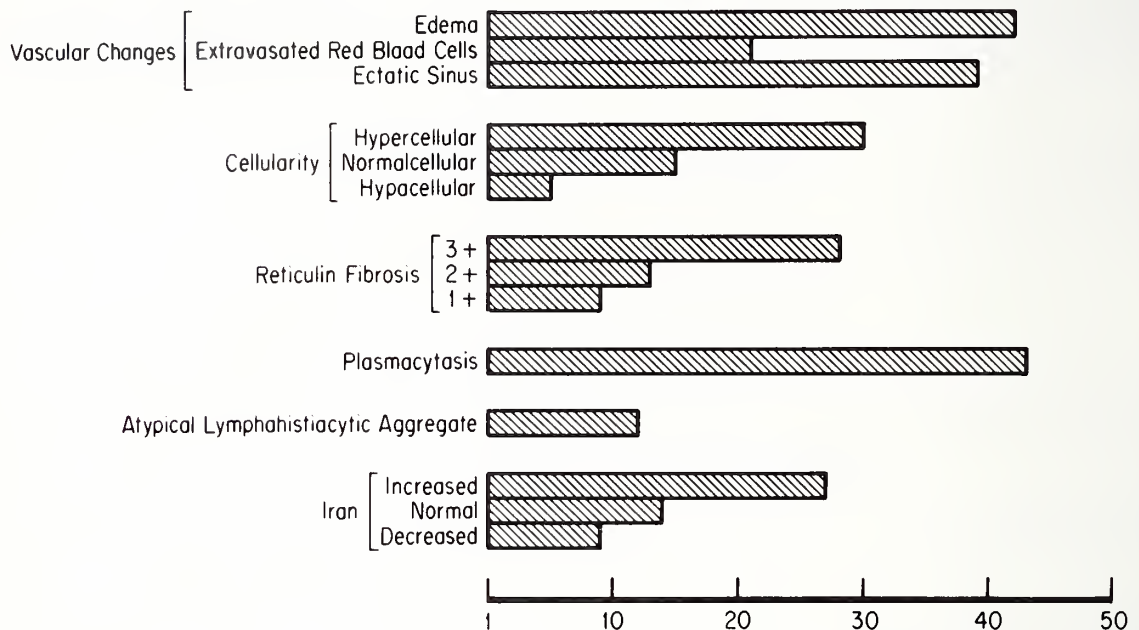


Figure 1. Histological changes present in bone marrow biopsies of 50 AIDS patients.

Table 1. Patient distribution according to sex and race and ethnicity.

Race	Males	Females
Black	33	6
Hispanic	3	3
White	2	2
Haitian	1	—
Total	39	11

Table 2. Frequency and types of identified hematologic abnormalities.

Abnormality	Number of Patients	Percent
Pancytopenia	12	24
Anemia (A)	35	70
Thrombocytopenia (T)	20	40
Leukopenia (L)	27	54
(A) & (L)	15	30
(A) & (T)	5	10

tients treated for AIDS at UMDNJ-New Jersey Medical School/University Hospital, Newark, during an 18-month period ending June 1987. Biopsies were included only if the patients had fulfilled the diagnostic criteria for AIDS, as established by the Centers for Disease Control. The medical charts were reviewed for data including age, sex, race, drug habits, sexual preferences, clinical presentations, peripheral blood count, presence of opportunistic infections, and status regarding HIV antibody tests by ELISA and Western Blot assay. The purpose of bone marrow aspiration and biopsy was evaluation and correlation of decreased numbers of any cell line on peripheral blood smear.

Bone marrow specimens, obtained from the posterior iliac crest with a Jamshidi needle, were fixed in 10 percent buffered neutral formalin, decalcified, and processed by routine histological techniques. Tissue sections were cut at 4 μ intervals and stained with hematoxylin and eosin (four slides). Iron stores were evaluated by Prussian blue stain (two slides), reticulin fibers by the methodology of Steiner and Steiner (two slides), mycobacteria by the Kinyoun stain (two slides), and fungi by Gomori's methenamine silver stain (two slides). Cellularity and reticulin fibrosis were estimated by the methods of Hartsock⁸ and Bauermeister,⁹ respectively.

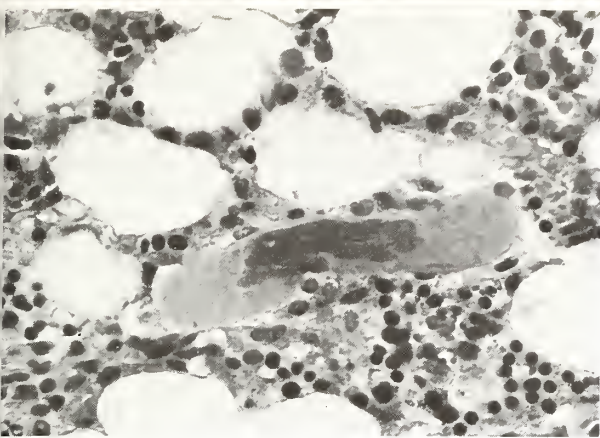


Figure 2. Giant megakaryocytes (hematoxylin and eosin (H&E) stain, x 40).

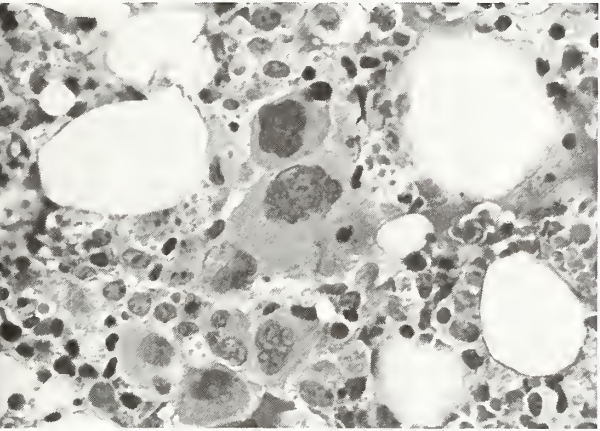


Figure 3. Micromegakaryocytes and atypical megakaryocytes with nuclear abnormalities and excessive nuclear lobation (H&E, x 40).

RESULTS

The 50 patients from this study at UMDNJ-New Jersey Medical School/University Hospital were 22 to 50 years of age, with a mean age of 30 years. Of this number, 78 percent were men. The University Hospital is located in a central urban, lower socioeconomic region, which, in part, accounts for the racial distribution where 78 percent of the patients were black, 12 percent of the patients were Hispanic, 8 percent of the patients were white, and 2 percent of the patients were Haitian (Table 1). Most individuals (92 percent) were at high risk for exposure to HIV. Approximately 78 percent of individuals had a history of intravenous drug abuse, 8 percent of individuals were homosexual or bisexual, 10 percent of individuals had spouses who had previously died of AIDS; and 8 percent of individuals had no identifiable risk factors for HIV exposure. HIV antibody was detected by enzyme immunoassay in 74 percent of the patients and confirmed by Western Blot assay in every case. The most frequent clinical complaint was fever (94 percent). Associated symptoms and signs were

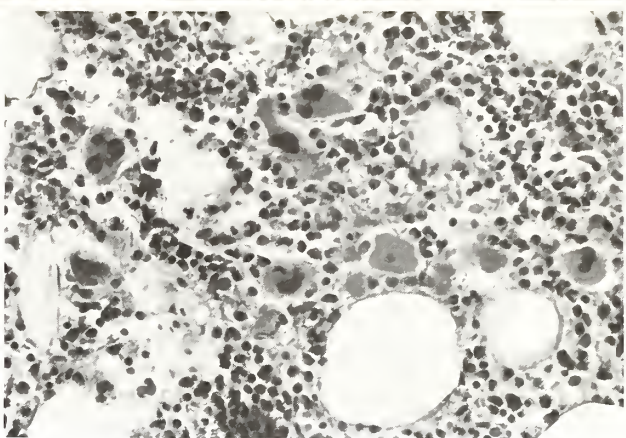


Figure 4. Megakaryocytes with nuclear hyperchromatism (H&E, x 40).

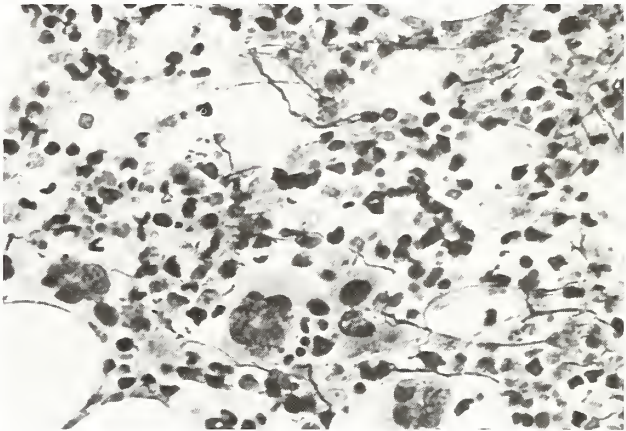


Figure 5. Reticulin fibrosis (reticulin stain).

weight loss (50 percent), cough (24 percent), diarrhea (22 percent), and headache (12 percent). Thirty-eight percent of the patients exhibited generalized lymphadenopathy. Hepatosplenomegaly was present in 12 percent. Opportunistic infectious agents included *Candida* (46 percent), *Pneumocystis* (28 percent), and, rarely, *Cryptococcus* and *Toxoplasma*. Every patient had hematological abnormalities, including an absolute lymphopenia (Table 2), and most patients (70 percent) were anemic. The hemoglobin (Hb) values were less than 12.5 gm in males and 11.5 gm in females. Thrombocytopenia (platelet count, $<150,000/\mu\text{l}$) was evident in 40 percent of individuals and leukopenia (white blood cells (WBCs), $<2,000/\mu\text{l}$) was evident in 30 percent of individuals. Also, 24 percent of the patients showed pancytopenia, and, of these, 25 percent presented with idiopathic thrombocytopenic purpura. While 14 percent of the bone marrow biopsies were positive by culture for *M. tuberculosis*, only two biopsies had well-defined granulomas with identifiable acid-fast bacilli. The findings in the bone marrow biopsies are sum-

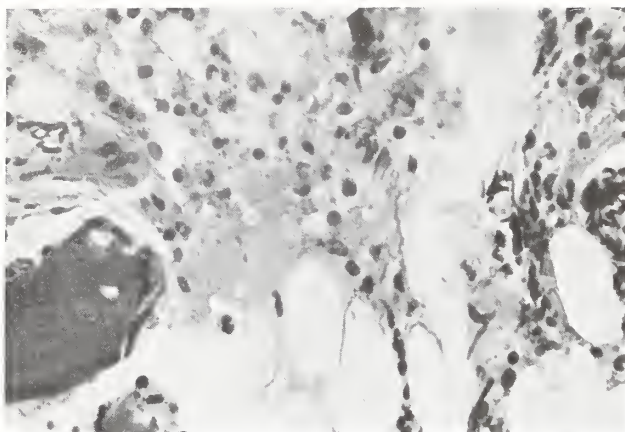


Figure 6. Stromal edema (H&E, x 40).

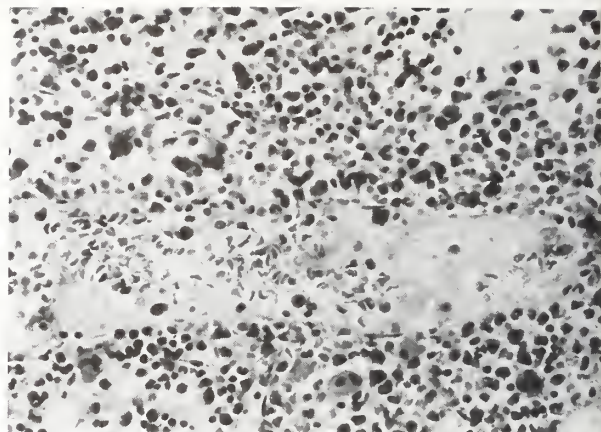


Figure 8. Ectatic sinusoids with intravascular hematopoiesis and extravasated red blood cells (H&E, x 40).

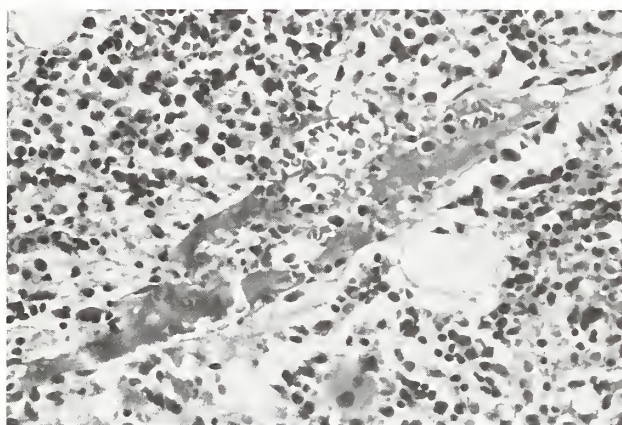


Figure 7. Ectatic sinusoids with intravascular hematopoiesis and extravasated red blood cells (H&E, x 40).

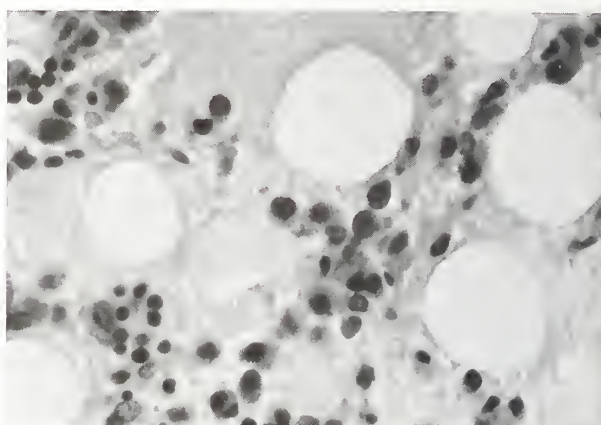


Figure 9. Gelatinous transformation with focal hypoplasia of bone marrow.

marized in Figure 1. Megakaryocytes were increased markedly; atypical morphology, found in 94 percent of the biopsies, included abnormalities of size (giant megakaryocytes and micromegakaryocytes), shape, and nuclear staining and configuration (hyperchromatism and excessive nuclear lobation (Figures 1 to 4). Increased deposition of reticulin fibers occurred in 86 percent of specimens (Figure 5), while stromal edema (Figure 6) was found in every case. Vascular abnormalities included ectatic sinusoids with intravascular hematopoiesis (84 percent) and extravasated red blood cells (RBCs) (56 percent) (Figures 7 and 8). Gelatinous transformation (serous atrophy) with focally hypoplastic marrow was detected in 30 percent of cases (Figure 9). Bone marrow macrophages were increased in 70 percent of cases and mast cells were increased in 2 percent of cases in our study.

DISCUSSION

The hematopoietic inductive microenvironment (HIM) refers to the stroma which consists of cellular elements which are presumed to act in concert to provide the most favorable milieu for proliferation

of the hematopoietic parenchymal cells. The important constituents are: 1) the reticular cells, which are large cells having branching cytoplasm, intimately associated with the meshwork of "reticulin" fibers forming the supporting structure of the marrow; 2) the sinusoidal microcirculation; and 3) the neural elements.¹⁰

Disruption of HIM homeostasis can result from irradiation, graft versus host reaction, drugs, and certain viruses. These perturbations in homeostasis are morphologically accompanied by reticulin fibrosis, sinusoidal ectasia, extravasated RBCs, edema, marked proliferation and atypia of megakaryocytes, lymphoid nodule formation, and plasmacytosis, and in an increased number of mast cells and macrophages.¹¹

Alterations in the HIM, which include reticulin fibrosis and abnormalities in the sinusoidal microcirculation, have been implicated in the pathogenesis of both idiopathic myelofibrosis (IMF) and aplastic anemia.¹²⁻¹³ Bone marrow biopsies from patients with IMF exhibit marked reticulin fibrosis while the megakaryocyte function in these patients is abnormal.^{14,15} Megakaryocytes produce platelet

erived growth factor (PDGF) and megakaryocyte-derived growth factor (MKDGF), both of which stimulate the reticular cells to produce reticulin. It is the abnormal megakaryocytic function in patients with IMF which is believed responsible for the early myelofibrosis evident histologically. As the morphologic appearance of the fibrosis in patients with AIDS is similar to that in IMF, a similar mechanism of megakaryocyte growth factor release may be operative.

The marked morphologic atypia present in megakaryocytes from patients with AIDS raises the concern that megakaryocyte function is disrupted. As various types of viruses can infect megakaryocytes, these cells are suitable hosts for viral replication.¹⁶⁻¹⁸ From this, it is inferred that megakaryocytes are capable of being infected by HIV and that "HIV-infection" may be responsible for the morphologic atypia evident in these cells. The "HIV-infection" also may disturb megakaryocyte function, ultimately disrupting HIM homeostasis to culminate in bone marrow and hematologic aberrations.

The bone marrow morphology is similar in patients with AIDS and patients with aplastic anemia. The hypothetical pathogenesis of aplastic anemia evolves about pathologic alteration of the sinusoidal microcirculation, the "sinocapillaropathy" which is

manifest by exudation.¹² Exudation is common in AIDS marrow biopsies, which suggests that a similar form of injury to the sinusoidal microcirculation may occur in AIDS.

The observation that bone marrow specimens of patients with AIDS have morphological features also seen in IMF and aplastic anemia suggests that the marrow alterations in AIDS are due to a disrupted HIM. Given that megakaryocytes can support viral replication and that megakaryocyte atypia and subsequent reticulin fibrosis are prominent histologic features of AIDS bone marrow biopsies, it is important to determine if HIV infection of megakaryocytes is ultimately responsible for these changes.

The HIV virus principally infects and destroys the "T"-lymphocyte. Reports indicate that the virus also can infect myeloid cells in the bone marrow and macrophages in the brain tissue.¹⁹⁻²⁰ Studies currently are in progress in our laboratory to determine the frequency of macrophage infection.

HIV particles have not been reported in megakaryocytes. Recently, we observed viral-like particles in the megakaryocytes of an infected individual (unpublished data). Studies are being performed with HIV probes to further document this observation. ■

REFERENCES

1. Abrams DI, Chinn EK, Lewis BJ, et al.: Hematologic manifestations in homosexual men with Kaposi's sarcoma. *Am J Pathol* 81:13-18, 1984.
2. Castella A, Croxson TS, Mildvan D, et al.: The bone marrow in AIDS. *Am J Clin Pathol* 84:425-432, 1985.
3. Geller SA, Muller R, Greenberg ML, et al.: Acquired immunodeficiency syndrome. Distinctive features of bone marrow biopsies. *Arch Pathol Lab Med* 109:138-141, 1985.
4. Osborne BM, Guarda LA, Butler JJ: Bone marrow biopsies in patients with the acquired immunodeficiency syndrome. *Hum Pathol* 15:1048-1053, 1984.
5. Schneider DR, Picker LJ: Myelodysplasia in the acquired immunodeficiency syndrome. *Am J Clin Pathol* 84:144-152, 1985.
6. Spivak JL, Bender BS, Quinn TC: Hematologic abnormalities in the acquired immunodeficiency syndrome. *Am J Med* 77:224-228, 1984.
7. Spivak JL, Selonic SE, Quinn TC: Acquired immunodeficiency syndrome and pancytopenia. *JAMA* 250:3084-3087, 1983.
8. Hartsock RJ, Smith EB, Petty CS: Normal variations with aging of the amount of hematopoietic tissue in bone marrow from the anterior iliac crest. *Am J Clin Pathol* 43:326-331, 1964.
9. Bauermeister DE: Quantitation of bone marrow reticulin—a normal range. *Am J Clin Pathol* 56:24-31, 1971.
10. Weiss L: The hematopoietic microenvironment of the bone marrow: An ultrastructural study of the stroma in rats. *Anat Rec* 186:161-184, 1975.
11. Trentin JJ: Hemopoietic inductive microenvironment (HIM): Implications for myelofibrosis advances. *Adv Biosci* 16:77-86, 1975.
12. Umehara S: Bone marrow stroma in aplastic anemia. *Proc First Intern Symp AA* 176:109-121, 1976.
13. Burkhardt R, Bart R, Beil E, et al.: Myelofibrosis: Osteosclerosis syndrome. Review of literature and histomorphology. *Adv Biosci* 16:9-56, 1975.
14. Malaspina HC, Gay RE, Resnick G, et al.: Characterization of human bone marrow fibroblast colony-forming cells (CFU-F) and their progeny. *Blood* 56:289-301, 1980.
15. Malaspina HC, Rabellino EM, Yen A, et al.: Human megakaryocyte stimulation of proliferation of bone marrow fibroblasts. *Blood* 57:781-787, 1981.
16. Young N, Mortimer P: Viruses and bone marrow failure. *Blood* 63:729-737, 1984.
17. Espinoza C, Kuhn C: Viral infections of megakaryocytes in varicella with purpura. *Am J Clin Pathol* 61:203-208, 1974.
18. Zinkham WH, Medearis DN, Osborn JE: Blood and bone marrow findings in congenital rubella. *J Pediatr* 71:512-524, 1967.
19. Busch M, Beckstead J, Gantz D, Vyas G: Detection of human immunodeficiency virus infection of myeloid precursors in bone marrow samples from AIDS patients. *Blood* 68:112a, 1986.
20. Mark JL: How the AIDS virus may hide in macrophages. *Science* 241:660, 1988.

MEDICAL MANAGEMENT

Mary Ann Hamburger, Associates

A Medical Management Consultant

Offering Physicians Her Unique and
Specialized Services in the Area of
Medical Management Consultation
Call the Physician's Consultant

Mary Ann Hamburger

201-763-7394



Doctors Disposal Service, Inc.

2110 Maple Avenue
South Plainfield, NJ 07080

Licensed by:
STATE OF NEW JERSEY
Department of Environmental Protection

Professional removal of sharps and special
medical waste ...
Disposal by incineration ...
Reliable, worry free service ...
Reasonable rates ...

For information in New Jersey call toll free
1-800-447-0026

ARE YOU PROPERLY CLASSIFIED? PROFESSIONAL MALPRACTICE LIABILITY

OCCURRENCE PLUS—1/3,000,000 LIMITS

New Doctors 50% of Prem.	Urology-Surg.	\$19,476
GP—No Surgery \$ 5,773	Neurosurgery	\$42,652
Orthopedic Surg. \$35,643	Obst-Gynec.	\$34,309
Internal Medicine \$ 7,412	GP—Minor Surg.	\$ 7,412
Colon & Rectal	Cardiology	\$ 5,773
Surgery \$13,445	Neurology	\$ 3,986

OVER 100 OTHER CLASSIFICATIONS

BOYNTON & BOYNTON, INC.

42 MONMOUTH ST.
P.O. BOX 887
RED BANK, N.J. 07701

MEDICAL HOTLINE 1-800-822-0262

Chondrosarcoma and Malignant Lymphoma

LINDA MURAKATA, MD
ANIS F. RANGWALA, MD

We describe two primary malignancies occurring simultaneously. The coexistence of chondrosarcoma and malignant lymphoma, small lymphocytic type (MLSL) (WDLL) is a rare occurrence. In this case, the untreated malignant lymphoma appears to have increased the aggressiveness of the chondrosarcoma through its adverse effect on the host's immune system.

Low-grade chondrosarcomas are reported to metastasize rarely (5 percent).^{4,5} If the lesion is ablated by en bloc resection, the overall five-year survival rate may be as high as 76 percent and the ten-year survival rate may be as high as 69 percent.⁵ In this case, the patient was found initially to have chondrosarcoma grade II. Eighteen months later, the patient developed a low-grade malignant lymphoma, small lymphocytic type (MLSL) (well

differentiated lymphocytic lymphoma-Rappaport classification) (WDLL), stage IV, and, at that time, was found to have metastatic chondrosarcoma in the lung. Most MLSLs are not treated unless symptomatic, because of their indolent course.¹⁻³ However, the patient had a rapid downhill course and expired after 18 months with multiple brain lesions which on CAT scan were reported to be most consistent with metastatic neoplastic disease. A possible explanation for this aggressive behavior may be explained by recent evidence which shows natural killer (NK) cell activity to be decreased in untreated patients with malignant lymphoma,^{6,8} as well as the presence of multiple coexisting immune defects.⁸

Drs. Murakata and Rangwala are affiliated with the Department of Pathology, Monmouth Medical Center, Long Branch. Requests for reprints may be addressed to Dr. Murakata, 23 Elm Place, Eatontown, NJ 07724.

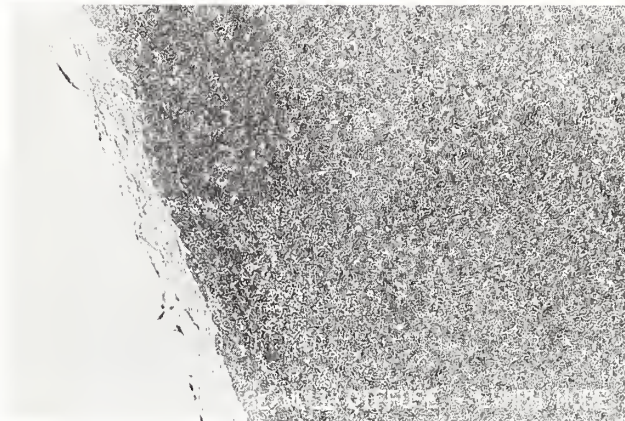


Figure 1. Low-magnification malignant lymphoma, small lymphocytic type/WDLL diffuse-lymph node, hematoxylin and eosin (H&E stain).

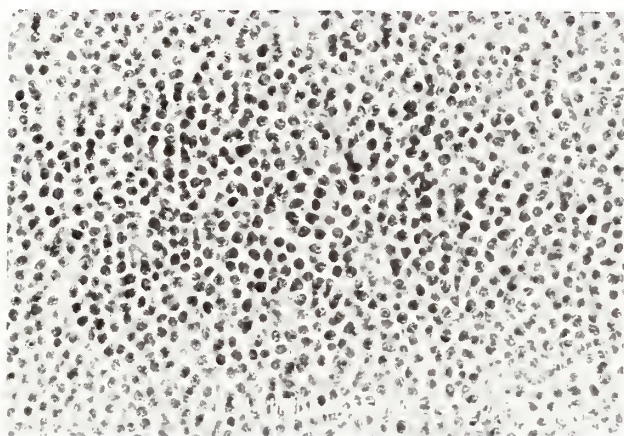


Figure 2. High-power malignant lymphoma, small lymphocytic type/WDLL diffuse-lymph node (H&E stain).



Figure 3. Low-magnification bone marrow biopsy-malignant lymphoma, small lymphocytic type/WDLL (H&E stain).

CASE REPORT

A 58-year-old white man in good health developed pain in his right 10th rib area in February 1983. He was a nonsmoker and nonalcoholic. Over a period of a year, multiple x-rays were reported to be negative.

In August 1985, a cystic lesion was seen in the 10th rib in the area of his pain. CAT scan showed a large

lesion which protruded into the right retroperitoneal area as well as outwardly into soft tissues of the chest wall. An open lung biopsy showed it to be a chondrosarcoma. The lesion then was resected en bloc along with five ribs, skin, and muscle. The margins of resection were free of tumor. The chondrosarcoma was diagnosed as a grade II lesion. The tumor measured 6 cm in its greatest dimension, and it infiltrated the capsule and adjacent soft tissues.

Microscopically, the mass was composed of a moderately cellular tumor with nodules of spindle cells containing hyperchromatic, irregular nuclei without nucleoli, in a blue-gray myxoid matrix, and surrounded by bands of collagen. No mitoses were seen and there was no evidence of lacunae formation. No other malignancy was found in the bone marrow of the ribs or the soft tissues and no further treatment was given.

In February 1986, the patient noticed enlarging "lumps" in his neck over a one-year period, and was readmitted. Lymph node biopsy was performed and three lymph nodes were removed which contained low-grade MSL type (WDLL). Microscopic examination showed a diffuse infiltration of uniform, small, round lymphocytes with clumped chromatin and scanty cytoplasm (Figures 1 and 2). Occasional nuclei showed small and inconspicuous nucleoli. A complete blood count revealed 8.6 K/ccm WBCs with 37 percent lymphocytes. Peripheral blood smears showed lymphocytes which were normal in number and morphology. However, bone marrow biopsies showed low-grade MSL (Figures 3 and 4). During this hospitalization, resection of a nodule within the right upper lung parenchyma was performed. This was found to be a metastatic chondrosarcoma.

Microscopically, this 1.3 cm lesion was moderately cellular and composed of cells and matrix surrounded by bands of collagen (Figures 5 and 6). Spindle cells embedded in a myxoid matrix stained blue-gray, with hyperchromatic, irregular nuclei without nucleoli and no apparent mitoses. Islands of tumor cells focally infiltrated the capsule and vascular invasion was present. Because of the apparent indolent nature of MSL, no treatment was given.

The patient did well for 5 months, then developed blurred vision, was unable to read, and dropped things from his left hand. A CAT scan of the head showed multiple enhancing lesions in the cerebral hemispheres, compatible with metastatic neoplastic disease. Whole brain radiation (3000 rads) was given, but the patient's condition deteriorated over the following 3 months; he expired 18 months after the diagnosis of malignant lymphoma. Autopsy was not permitted.

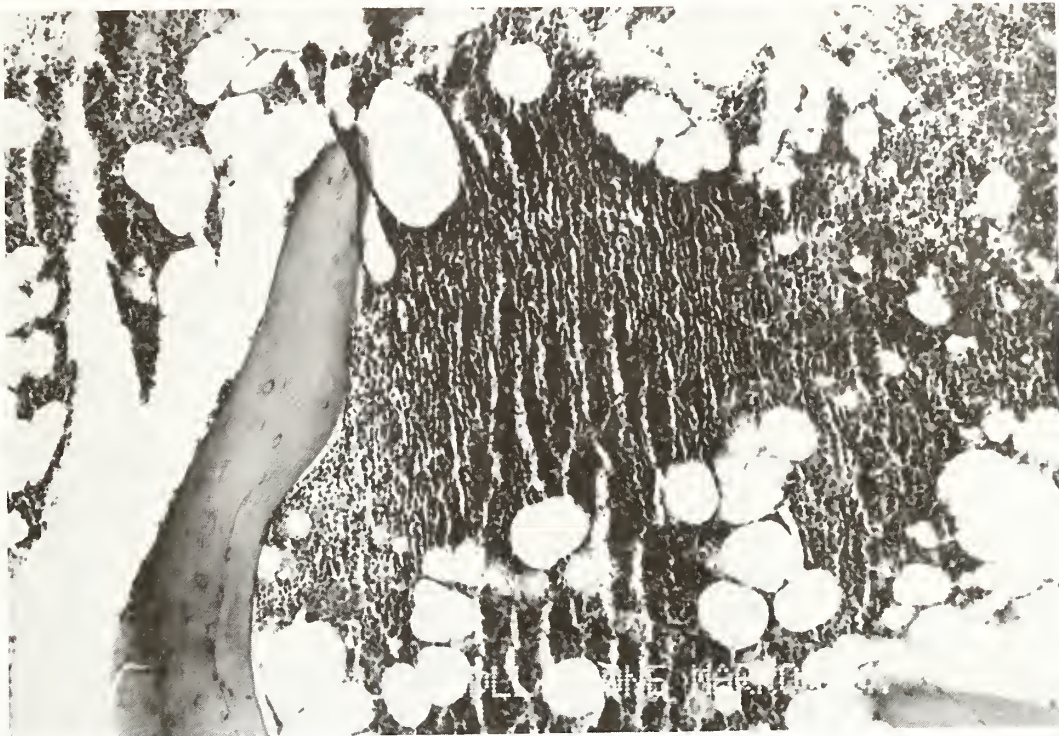


Figure 4. High-power bone marrow biopsy-paratrabecular nodule with malignant lymphoma, small lymphocytic type/WDLL (H&E stain).

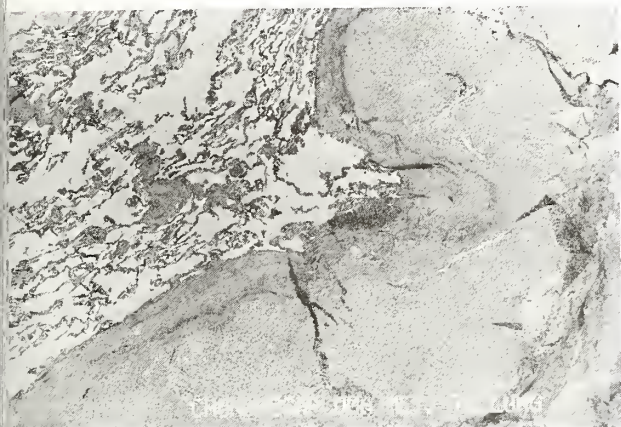


Figure 5. Low-magnification pulmonary metastatic nodule chondrosarcoma (H&E stain).

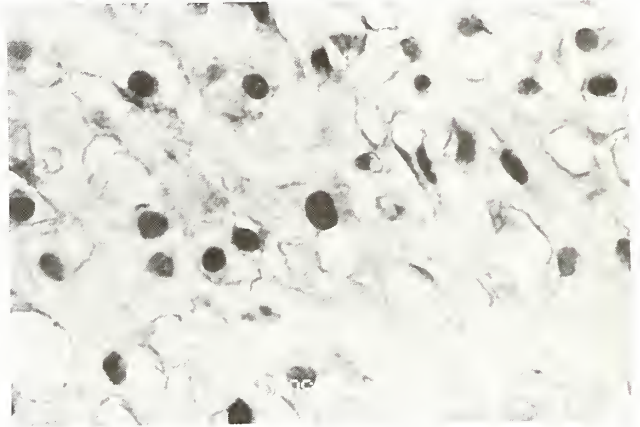


Figure 6. High-power metastatic pulmonary chondrosarcoma, grade II (H&E stain).

DISCUSSION

Chondrosarcomas are slow-growing malignant tumors that may be present for many years before becoming clinically apparent.⁵ Chondrosarcomas are graded according to the degree of nuclear alteration. Grade I chondrosarcomas have small, densely stained nuclei, absence of highly cellular areas, and lack of mitoses. These are locally aggressive tumors with potential for recurrence. They usually do not metastasize. Grade II tumors show greater evidence of malignancy with medium- to large-sized nuclei, visible intranuclear detail, and presence of highly cellular areas. Mitoses are present but rare—fewer

than two per ten high-power microscopic fields. These lesions rarely metastasize. Grade III tumors show an obviously malignant pattern with cellular areas that contain two or more mitoses per ten high-power fields. These have a high potential for metastases. Therapy for chondrosarcoma is complete ablation of the lesion by en bloc resection. High-grade chondrosarcomas are more aggressive and more likely to metastasize. The predominant site of metastasis is pulmonary. The overall five-year survival rate for the entire group is 28 to 53 percent.⁵ With treatment, it may be as high as 76 percent. The overall ten-year survival rate is 39 percent, and with treatment it may be as high as 69 percent.

In our present case of low-grade chondrosarcoma, resected en bloc, the patient could have expected to live another ten years, but his second malignancy (malignant lymphoma, small lymphocytic type) which also is classified as low-grade with an indolent course, might have upgraded the aggressiveness of chondrosarcoma to a higher grade with poorer prognosis.

Recent studies have found NK cell activity to be decreased in peripheral blood lymphocytes in untreated patients with malignant lymphoma.^{6,7} Experimental studies have emphasized the role of NK lymphocytes in anti-tumor activity. NK cells are spontaneously cytotoxic toward a variety of cultured target cells, in vitro, especially of neoplastic origin. A good correlation exists, in murine models, between high in vitro NK activity and in vivo resistance to neoplasia. Another study reported that injections of NK-enriched lymphocytic populations can delay tumor growth in vivo.⁷ Leu 7 (HNK-1), a monoclonal antibody used to identify human NK/killer cells, was studied in the reactive lymphoid tissues of humans and showed that Leu 7+ cells were concentrated in the pale zone of germinal centers. Of the malignant lymphomas, follicular lymphoma most consistently has numerous admixed Leu 7+ cells, and lymphoblastic lymphoma the least. These findings suggest that Leu 7+ cell accumulation in normal and neoplastic lymphoid tissue is associated in part with normal germinal centers and/or the presence of neoplastic germinal centers.⁶ Circumstantial evidence reported in animals and humans, correlates low NK activity, generally in peripheral blood, with lymphoma growth, prevalence, or presence. Interferon-activated NK cells lyse neoplastic B-cell lines, as well as fresh cells from some lymphoid neoplasms. Another study found that natural cell-mediated cytotoxicity (NCC) values in untreated patients with various nonlymphoid malignancies is not different from that observed in normal individuals.⁷ Previous studies of large numbers of cancer patients in which there was low NK activity, was found only in patients suffering from advanced metastatic

disease, whereas in patients affected with malignant lymphoma of both Hodgkin and non-Hodgkin type the mean NCC value was strikingly reduced and to the same degree in stage I-II patients as in stage III-IV patients.⁷

Another study characterizes multiple immune defects in human malignant lymphoma.⁸ Data show that a reversible defect in proliferative responsiveness exists among the majority of untreated patients. The mechanism of the reversible defect is unknown but could represent the in vitro loss of functional suppressor cells as seen in humans with systemic fungal infections. Increased frequencies of peripheral blood cells having ultrastructural evidence of damage in patients with lymphoma indicate the existence of intrinsic abnormalities. Several investigations of mitogen and mixed lymphocyte reaction (MLR) responses in human malignant lymphoma have documented that suppressor cells might contribute to impaired lymphocyte reactivity. Suppressor activity occurs in approximately 60 percent of patients with NHL and only 30 percent of those with HD.⁸ Other studies have shown that monocytes and T-cells can be responsible for the suppression of mitogenesis in human malignant lymphoma. It was found that in patients with NHL, suppressor-cell activity tended to be associated with diffuse histology and the presence of constitutional symptoms.⁸ We, therefore, speculate it is very possible that this untreated low-grade MLSL was responsible for the increased aggressiveness of the patient's low-grade chondrosarcoma.

The coexistence of untreated malignant lymphoma with a low-grade second primary malignancy, should alert the clinician to expect a more aggressive behavior of the nonlymphomatous neoplasm. This may be due to the weakened ability of the patient's immune system to launch a full-scale antitumor attack on the neoplastic target. Without a check-system for wandering tumor cells, one can expect high-grade behavior and should consider treating the nonlymphomatous malignant neoplasm with appropriate but aggressive therapy. ■

REFERENCES

1. Gaynor ER, Ultman JE: Non-Hodgkin's lymphoma: Management strategies. *N Engl J Med* 311:1507-1509, 1984.
2. Gerassimos AP, Roussou PA, Kittas C, et al.: Patterns of bone marrow involvement in chronic lymphocytic leukemia and small lymphocytic (well differentiated) non-Hodgkin's lymphoma. *Cancer* 54:702-708, 1984.
3. Horning SJ, Rosenberg SA: The natural history of initially untreated low-grade non-Hodgkin's lymphomas. *N Engl J Med* 311:1471-1475, 1984.
4. Sanerkin NG: The diagnosis and grading of chondrosarcoma of bone. *Cancer* 45:582-594, 1980.
5. Silverberg SG: Neoplasms and tumorlike lesions of bone. *Surg Pathol* 1:420-423, 1983.
6. Swerdlow SH, Murray LJ: Natural killer (Leu 7+) cells in reactive lymphoid tissues and malignant lymphomas. *Am J Clin Pathol* 81:459-463, 1984.
7. Tursz T, Kokhelar MC, Lipinski M: Low natural killer cell activity in patients with malignant lymphoma. *Cancer* 50:2333-2335, 1982.
8. Whisler RL, Murray L, Roach RW: Characterization of multiple immune defects in human malignant lymphoma. *Cancer* 53:2628-2634, 1984.

Bilateral Adrenal Hemorrhage

ANNA M. CHAMPLIN, MD
JOEL A. BUDIN, MD

The diagnosis of bilateral adrenal hemorrhage, a potentially fatal complication of anticoagulation therapy, can be made by computed tomography (CT) scan. We present a case of a heparinized patient with CT examination of the adrenal glands before and after the onset of acute adrenal insufficiency.

Hemorrhagic complications of anticoagulant therapy are commonly encountered. Bilateral adrenal hemorrhage, however, is a rare and potentially fatal complication of anticoagulant therapy that can be suspected clinically.^{1,4} There have been several case reports of bilateral adrenal enlargement, presumably due to hemorrhage, demonstrated by computed tomography (CT).⁵⁻¹¹ We present a case of bilateral adrenal hemorrhage in a heparinized patient who had CT examinations just before and after the onset of adrenal insufficiency.

CASE REPORT

An 86-year-old white man was admitted with right calf pain. He was placed on a heparin drip of 800 U/h after a 5,000 U intravenous bolus with the diagnosis of thrombophlebitis. Three days later, he developed shortness of breath and chest pain. Multiple pulmonary emboli were documented by a lung ventilation-perfusion scan. The intravenous heparin drip was increased to 1,000 U/h. Nine days following admission, a CT scan of the chest was performed to evaluate pleural densities seen on a chest radiograph. The adrenal glands were normal in size, contour, and attenuation (Figure 1). Three days later, the patient became confused, febrile, hypotensive. A workup for sepsis, including sputum, cerebro-

spinal fluid, stool, blood, urine, and throat cultures was negative. A CT scan of the brain showed cerebral atrophy. A repeat perfusion lung scan showed resolving pulmonary emboli. The patient was placed on intravenous antibiotics and intravenous steroids for presumed septic shock. An abdominal CT scan was performed to search for a source of sepsis. The adrenal glands were found to be uniformly enlarged and hyperdense with loss of normal contour, a striking change from the prior CT scan (Figure 2). The diagnosis of acute adrenal hemorrhage was made. Antibiotics were discontinued and the patient continued to improve on intravenous steroids. The patient was discharged 26 days after admission on hydrocortisone, 20 mg in the morning and 10 mg in the evening, and warfarin 3 mg daily.

DISCUSSION

Bilateral adrenal hemorrhage following anticoagulation therapy has been reported to occur more frequently in patients over 60 years of age by McDonald.² Symptoms occur from 3 to 40 days after initiation of anticoagulation, with an average of 8 days. The manifestations of acute adrenal insufficiency include upper abdominal or flank pain, lethargy, hypotension, tachycardia, and fever. These are nonspecific and may mimic myocardial infarction, an acute surgical abdomen, or sepsis.⁸ The lack of specificity of symptoms may lead to a delay in diagnosis which contributes to the high mortality associated with this disease. Prompt treatment leads to survival in most cases.¹¹ ■

Drs. Champlin and Budin are affiliated with Hackensack Medical Center. Requests for reprints may be addressed to Dr. Champlin, Hackensack Medical Center, 30 Prospect Avenue, Hackensack, NJ 07601.

CASE REPORT

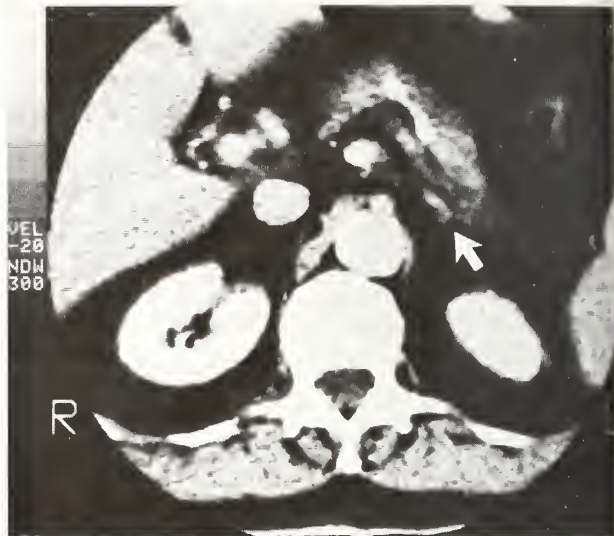
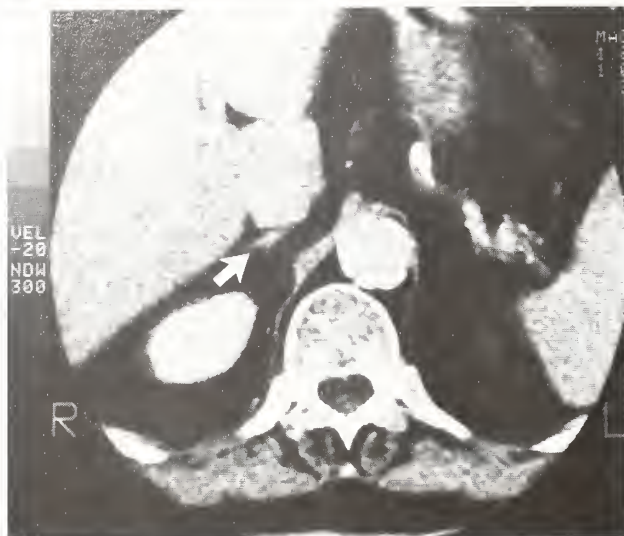


Figure 1. CT examination three days prior to onset of adrenal insufficiency showing normal adrenal glands.

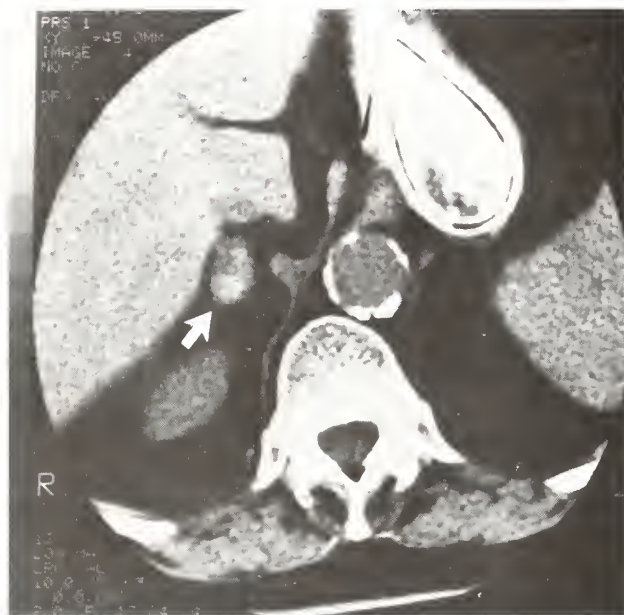


Figure 2. Enlarged, hyperdense adrenal glands demonstrated on CT after onset of symptoms.

REFERENCES

1. Harpur JR, Ginn WM Jr, Taylor W: Bilateral adrenal hemorrhage—a complication of anticoagulant therapy. Case report and review of the literature. *Am J Med* 32:984-988, 1962.
2. McDonald FD, Myers AR, Pardo R: Adrenal hemorrhage during therapy. *JAMA* 198:1052-1056, 1966.
3. Dreher WH, MacIndoe JH, Magnin GE, et al.: Acute adrenal insufficiency secondary to anticoagulant therapy. *Wis Med J* 70:144-147, 1971.
4. Amdor E: Adrenal hemorrhage during anticoagulant therapy. A clinical and pathological study of ten cases. *Ann Intern Med* 63:559-571, 1965.
5. Korobkin M, White EA, Kressel HY, et al.: Computed tomography in the diagnosis of adrenal disease. *AJR* 132:231-238, 1979.
6. Swift DE, Overholt EL, Travelli R: Methods of diagnosis of acute adrenal hemorrhage complicating anticoagulant therapy—abdominal CAT scanning. *Wis Med J* 80:25-28, 1981.
7. Albert SG, Wolverson MK, Johnson FE: Bilateral adrenal hemorrhage in an adult. Demonstration by computed tomography. *JAMA* 247:1737-1739, 1982.
8. Ling D, Korobkin M, Silverman PM, Dunnick NR: CT demonstration of bilateral adrenal hemorrhage. *AJR* 141:307-308, 1983.
9. Scott WW Jr, Fishman EK, Siegelman SS: Anticoagulants and abdominal pain. The role of computed tomography. *JAMA* 252:2053-2056, 1984.
10. Wolverson MK, Kannegiesser H: CT of bilateral adrenal hemorrhage with acute adrenal insufficiency in the adult. *AJR* 142:311-314, 1984.
11. Ognibene AJ, McBride H: Adrenal hemorrhage: A complication of anticoagulant therapy—a case history. *Angiology* 38:479-483, 1987.

NOTEBOOK

TRUSTEES' REPORT

A regular meeting of the Board of Trustees was held on June 4, 1989, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of our county society. A summary of significant actions follows:

Report of the President . . .

(1) County Medical Society Meetings . . . Noted Dr. Hirsch's interest in attending meetings of the county medical societies.

(2) Bergen County Medical Society Summary . . . Noted Dr. Hirsch's request that copies of the Bergen County Medical Society summary of MSNJ accomplishments be sent to trustees and all county societies.

(3) Recognition of Importance of Physician Input by Government

. . . Noted that Governor Kean, in his UMDNJ commencement address, spoke of the need for physicians to become involved in regulations and legislation.

(4) Meeting Dates . . . Noted the following important dates: June 7, 1989, for the Manpower Organization for Political Action; September 13, 1989, for an insurance seminar; November 15, 1989, for the Conference of Presidents; and January 17, 1990, for the Nominating Committee.

Report of Executive Director . . .

(1) CDS Regulations . . . Noted that discussion will be continued at the next meeting, with the Board having the opportunity to review the list of drugs involved in proposed CDS regulations.

(2) Physicians' Health Program

. . . Noted that a motion to gain access to certain treatment records was defended successfully by MSNJ.

(3) Special Assessment . . .

Noted that the suit started by Dr. Celestino Clemente because of the omission of his name from the *Membership Directory* for nonpayment of the special assessment was withdrawn.

(4) Medicare Update . . . Noted a report on the May 23, 1989, meeting of Mr. Maressa, Mr. Lucci, and representatives of Pennsylvania Blue Shield and HCFA (page 503).

(5) New Jersey State Medical Underwriters . . . Considered in Executive Session items concerning vacancies on the Board of the Underwriters.

(6) Medicare Participation . . .

Noted that AMA legal counsel objected to MSNJ Resolution #17 because it subjected the AMA to antitrust exposure and, therefore, would not be accepted by the AMA; Mr. Maressa requested written opinion.

(7) Medical Ethics . . . Noted the AMA report on medical ethics (page 504).

(8) Impact Analysis of Resource-Based Relative Value Scale . . . Received copies of the Department of Health and Human Services preliminary report on the impact of RBRVS on physicians' medical revenues.

(9) MSNJ Paid Membership . . .

Noted that as of June 1, 1989, paid membership totalled 7,111.

(10) Legislation . . .

(a) S-3440—Generic Substitution/Prescription Blank Change

. . . Approved changing position to no action on this proposed bill requiring physicians to write holographically "brand necessary" or "brand medically necessary" on prescription forms if generic drug is not to be dispensed.

(b) S-2936—Medical Discipline and Licensing . . . Noted that bill is expected to be posed for a vote in the near future.

(11) Medical Director-State Board of Medical Examiners . . . Noted that SBME is taking steps to fill the position of medical director.

(12) Medical Malpractice Surcharge . . . Noted Mr. Maressa and Judge Stern will attempt to have a meeting with the governor or his legal counsel before the commissioner of insurance moves on this issue.

(13) MSNJ Financial Statements . . . Approved financial statements for the period ending April 30, 1989.

Committee on Graduates of Non-U.S. Medical Schools . . .

(1) Appointments to Committee . . . Unanimously approved the following recommendation: That county medical societies be asked to submit the name of a non-U.S. medical school graduate for appointment to the Committee on Graduates of Non-U.S. Medical Schools.

(2) Minutes . . . Agreed to reinstate the previous policy that all councils and committees are to submit copies of the full minutes of their meetings to the Board.

Ad Hoc Committee on Women in

Medicine . . . Noted that Dr. Hirsch agreed to meet with the Committee and report to the Board.

Unfinished Business . . .

(1) **Special Committee on Drug and Alcohol Abuse . . .** Noted that this Special Committee had been discharged and its functions will be administered by the Committee on Physicians' Health.

(2) **Reimbursement for Completion of Social Security Disability Reports . . .** Noted that a letter will be sent to the director of the Division of Disability Determinations expressing MSNJ's concern and displeasure with his response to MSNJ's request for an increase in the fee schedule for a complete disability determination form. Also, instructed the Council on Medical Services to develop an abbreviated disability report form.

(3) **Surgical Assistants . . .** Directed that a letter be forwarded to Dr. Filippone indicating the Board's opposition to the performance of physician activities by nonphysicians.

(4) **Physician Attestation for Medicare Reimbursement—Resolution #24-1989 . . .** Noted that the House of Delegates adopted this Resolution (calling for MSNJ to take appropriate action to assure that the hospital not only be responsible for proper coding but also bear any liability for fines or penalties under federal law for incorrect coding and improper coding which go beyond the information attested to by the physician) and legal counsel recommended no further action.

(5) **Assignment of Laboratory Fees—Resolution #29-1989 . . .** Was reminded by Dr. Robins that he would appreciate any input regarding patient safety, convenience, and economy concerning laboratory services on an assignment basis.

New Business . . .

(1) **State Health Department**

Legislation . . . Postponed consideration of this item (legislation allowing a nonphysician to be commissioner of health) until executive session.

(2) **Insurance Interference with the Practice of Medicine . . .** Referred Dr. Weierman's preadmission certificate questionnaire to the Committee on Utilization Review Systems for evaluation and report. □

UMDNJ NOTES

Governor Thomas Kean, Commissioner of Health Molly Coye, State Police Superintendent Clinton Pagano, and other state officials convened at UMDNJ's Newark campus June 20 to inaugurate New Jersey's new state-of-the-art aeromedical rescue system, named Jemstar. Following a program at the Medical Science Building, the Governor led 200 guests and spectators and a contingent of media to a landing site opposite UMDNJ-University Hospital where the new medical helicopter, named Northstar, awaited public inspection. In the Jemstar program, Northstar covers northern New Jersey while another ship, Southstar, covers the southern part of the state. Southstar also was dedicated that day in a program at Cooper Hospital/University Medical Center, in Camden. Sikorsky S76-B helicopters, Northstar and Southstar are the largest and most technologically advanced medical aircraft of their kind in the world. They will deliver critically ill and injured patients to either of the state's two level I trauma centers, based at UMDNJ-University Hospital and Cooper, which is a core affiliate of UMDNJ.

Jemstar makes New Jersey one of the few states in the nation with a full-service aeromedical emergency program, providing services 24 hours a day, seven days a week. The program is supported by the

State Department of Health, the New Jersey State Police, and the hospitals. Northstar will cover the part of New Jersey in the 201 telephone area code. Southstar will cover those in the 609 area code. Both ships will back up each other. In addition to transporting emergency patients to the trauma centers, the Northstar and Southstar ships will fly patients to other specialty care centers such as the burn center at Saint Barnabas Medical Center, Livingston, major UMDNJ teaching affiliate. Interhospital transport also will be available for patients with special conditions such as cardiac disease and neonatal problems.

The state's two level I trauma centers are part of a new study designed to put the brakes on New Jersey's fast-rising automobile accident rates. Some 300,000 accidents are logged annually, including about 1,000 fatalities. The thrust of the study is to pinpoint highway danger areas and determine how to make them safe for our citizens.

The trauma centers—a UMDNJ-University Hospital and Cooper Hospital/University Medical Center, Camden—will compile information on highway traffic accidents and victims for one year starting last month. Funding for the study is provided by the New Jersey Division of Highway Safety. The information will be recorded, updated, and computerized for analysis. When completed, the study will act as a model for a future statewide automobile injury reporting system and serve as a preventive tool.

UMDNJ's Board of Trustees has approved in concept a proposal to develop a school of nursing. This would bring to seven the number of schools in the University network. An enabling resolution passed by the trustees at the June meeting described nurses as integral to the multidisciplinary health-care team and called for a collaborative

model of nursing education, practice, and research that "fosters upward career mobility" for nurses.

In proposing a school for nursing to the trustees, David M. Gibson, MA, acting dean of the UMDNJ School of Health Related Professions, said: "The University has consistently demonstrated its commitment to quality health professions education. As a profession with a clear identity and multiple levels of education, nursing deserves to be recognized by the University as a separate academic unit."

Gibson added, "This resolution will serve as public notice that UMDNJ is dedicated to nursing education as an integral part of the University's mission. We will attempt to develop nursing education programs on three levels—associate in science, bachelor of science in nursing, and master of science in nursing." The plan for a master's program is in the final approval stage of the New Jersey Department of Higher Education and calls for the program to take its first students in September 1990. Stanley S. Bergen, Jr, MD

elimination of the unsatisfactory elements of the bill that are pointed out. **Approval:** Com-mended as satisfactory, but not actively supported. **Disapproval:** Rejected as unsatisfactory, but not actively opposed. **No Action:** Con-sidered, but not regarded as sig-nificant or relevant to the proper interest of the Society.

SENATE

S-216-DiFrancesco—Board of Chiropractic Examiners. Creates a separate licensing and regulatory board for chiropractic. **No Action.**

S-938-Hurley—First Aid Dis-tricts. Provides that municipalities can adopt ordinances designating first aid districts. Each of the districts will become separate corporate bodies. All squads within the district are to be under the general supervision of the district authority. **Disapproved,** pend-ing requested amendments from MSNJ's Committee on Emergency Medical Care.

S-2214-Paterniti—Nursing Ser-vices. Creates a commission to study the overall performance and employ-ment conditions of nurses employed by the Department of Human Services. **No Action.**

S-2244-Ewing—Irradiated Foods. Declares irradiated foods to be

adulterated if processed and treated with cesium 137. **Disapproved,** be-cause there is no evidence of public harm from irradiated foods.

S-2458-McManimon—Medicare Information (same as A-2597). A sup-plemental appropriation to the De-partment of Health to implement a Medicare telephone information sys-tem. **No Action.**

S-2507-DiFrancesco—Medic Alert. Establishes the Medic Alert Demonstration Program, and appro-priates \$330,000. **Approved.**

S-3076-Paterniti—Heimlich Man-euver. Requires school boards to dis-tribute Heimlich maneuver educa-tional materials. **Approved.**

S-3079-VanWagner—Immunity. Requires physicians and others to re-port patients who have made defined threats against third parties to the local police. Grants civil immunity to the reporting practitioner. **Approved.**

S-3089-Stockman—Alzheimer's Disease. Designates November as Alzheimer's disease awareness month. **Approved.**

S-3091-Jackman—Dialysis. Creates a system for training and certi-fying dialysis technicians. **Approved.**

S-3104-Lipman—AIDS. Makes AIDS or HIV sensitivity reportable to the Department of Health and pro-vides for confidentiality. **Action De-ferred,** pending further information

LEGISLATION

The accompanying list presents, for your information and reference, the official positions of the Medical Society of New Jersey regarding bills currently in the Legislature. As further bills of medical interest are introduced, they will be con-sidered by the Society and sup-plemental bulletins will be sup-plied, indicating the Society's positions.

Positions. The Society has adopted the following regular range of official positions concern-ing proposed legislation: **Active Support:** All-out support for the measure. **Active Opposition:** All-out opposition for the measure. **Conditional Approval:** To in-dicate that the approval of the So-ciety is conditional, subject to

NEW JERSEY MEDICINE

presents

Continuing Medical Education in New Jersey

\$5.00

September 1989

Send check to: NEW JERSEY MEDICINE
Two Princess Road
Lawrenceville, NJ 08648
609/896-1766

from MSNJ's AIDS Task Force on this bill as amended.

S-3149-Ewing—Fetal Alcohol Syndrome (FAS). Requires retail establishments (alcohol) to post warnings about alcohol consumption during pregnancy. **Approved.**

S-3236-Rice—AIDS. Requires that persons convicted for using CDS shall be tested for AIDS and HIV sensitivity. **Action Deferred,** pending further information from MSNJ's AIDS Task Force.

S-3303-Graves—Anabolic Steroids. Requires the commissioner of health to study whether anabolic steroids should be classified as schedule II drugs and makes it a crime to distribute them without a prescription. **Conditional Approval,** pending notification that anabolic steroids will not be added to the schedule II listing.

S-3304-Cardinale—HMO. Prohibits the use of sex as a rating factor in HMO coverage. **No Action.**

S-3315-Bassano—Anabolic Steroids. Expands substance abuse education to include anabolic steroids and further provides for testing and referral for treatment. **Approved.**

S-3440-Codey—Generic Substitution/Prescription Blank Change. Changes prescription forms to facilitate use of generic drugs. **Active Opposition,** generic substitution is a questionable concept that must not be advanced without safeguards and testing. Generic drugs have not been tested through FDA-approved clinical trials. At this time, the FDA is reviewing the generic issue. Liberalization of the generic law is not indicated at this time.

SJR-77-Ambrosio—AIDS/Workplace. Calls for voluntary compliance in workplace with AIDS "bill of rights"; requires various departments to report on AIDS policies and programs. **Approved.**

SJR-79-Graves—Health Care Facilities and Providers. Establishes a commission to study the feasibility of an expanded system of hospital-based nursing schools. No MSNJ representation is provided. **Conditional Approval,** pending deletion of the word "free" from line 23 and the addition of a "physician" to the commission.

ASSEMBLY

A-865-Otlowski—Mental Health/

Involuntary Treatment. Assures persons receiving treatment on an involuntary basis in either a screening service or short-term facility of the same rights as patients who have been involuntarily committed to state or county psychiatric facilities. **Disapproved,** the rights as defined in this bill are unworkable in a facility set up to handle stays of a 24-hour duration. These issues should be established by institutional codes of behavior rather than state law.

A-1734-Martin—Drug Testing/Student Athletes. Requires high school students to be tested for drug abuse. **Disapproved,** because of the lack of confidentiality in this bill; also, it is potentially unconstitutional and discriminatory because it is only directed to students who participate in interscholastic athletics and certain other programs.

A-1868-Doyle—Public Health. Requires physicians to file reports with county health departments regarding illnesses caused by chemical pollutants. **Disapproved,** MSNJ is in agreement with the intent of this legislation, but has significant reservations about its implementation since the many bathers that use the ocean annually are tourists which makes follow-up impossible. MSNJ urges the Department of Health to explore other avenues to maintain the waters of the New Jersey Coast to prevent environmentally induced illnesses. (MSNJ already is on record as opposing ocean dumping.)

A-2499-Smith—Fetal Alcohol Syndrome (FAS). Establishes a FAS education and prevention program in the Department of Health and appropriates \$700,000. **Action Deferred,** pending referral of perinatologists correspondence received from Doctor Riggs to MSNJ's Committee on Maternal and Child Care for a final report.

A-2524-Miller—AIDS. Requires a physician to disclose positive results of AIDS test to patient's spouse. **Conditional Approval,** 1. Physician shall inform patient spouse, if any. 2. An HIV positivity, which has been confirmed, shall be reported to the Department of Health, state of New Jersey and all contacts be notified by the appropriate Division within the Department of Health. 3. Throughout the

bill "HTLV III" be changed to "HI

A-2597-Colburn—Medicare Information (same as S-2458). A supplemental appropriation to the Department of Health to implement Medicare telephone information system. **No Action.**

A-3060-Singer—Nursing Services in State Facilities. Creates a committee to study the quality of nursing services in state-operated facilities to evaluate what must be done to assure quality nursing services. **No Action.**

A-3206-Bush—Nursing. Creates a committee to review the employment practices of the state government regarding nurses to recommend methods to assure that high-quality staffs are available. **No Action.**

A-3736-Duch—Criminal Responsibility. Provides for the commitment of persons who are acquitted because of mental disease or defect if the defendant is a danger to himself or others. **Approved.**

A-3738-Girgenti—Orthotists and Prosthetists. Provides for the licensing and regulation of orthotists and prosthetists through an advisory committee in the Division of Consumer Affairs. Physicians are exempted from the requirements of the act. **Action Deferred,** pending further clarification as to licensing and certification.

A-3791-Girgenti—Allied Health. Requires regulatory agencies to certify or accredit allied health personnel to include instruction in infection prevention and control. **No Action.**

A-3891-Roberts—Mobile Intensive Care. Establishes a mobile intensive care fund. Hospitals would be reimbursed for MICU services. Patients could not be billed directly, but hospitals could bill third-party payors. **Action Deferred,** pending further information from MSNJ's Committee on Emergency Medical Care.

A-3986-Villapiano—Dioxin Research. Creates a special "consortium" to conduct research on dioxin contamination. Appropriate \$2,000,000. **Disapproved,** extensive research needs to be done on the federal level. The amount proposed for a state program is woefully inadequate.

A-3991-Doria—Podiatry. Permits podiatrists to certify physical disability for handicapped parking privilege. **Approved.**

A-4014-Haytaian—Nursing Aides. Provides for nurse aide training programs. **Disapproved.** This bill would fragment a process that already is well addressed without legislation.

A-4045-Colburn—Medicaid. Extends Medicaid coverage to certain pregnant women and children under one year (family income is 185 percent of federal poverty level); children up to five years of age if family income is 100 percent of federal poverty level. **Active Support.**

A-4046-Shusted—Structured Payments. Provides for structured payments in civil actions against health care providers when future damages exceed \$250,000. An annuity contract must be offered to guarantee the future payments. **Active Support.**

A-4142-Kavanaugh—Commissioner of Health. Deletes the current requirement of a medical license to be commissioner of health. Provides that there be a deputy commissioner who is a licensed physician. **Action Deferred.** Pending further information from MSNJ's Council on Public Health regarding what other state requirements and experiences have been.

A-4179-Felice—Organ Donations. This bill deletes the requirement in the law that a completed organ donation option certificate be attached to a death certificate in order for the death certificate to be deemed complete. This bill is necessary in order to ensure the prompt handling of the deceased once a death certificate is prepared. **Approved.**

A-4329-Hardwick—Eye Enucleation. Allows eye bank technicians and other medical students to enucleate eyes. **Approved.**

AR-132-Kavanaugh—Uncompensated Care. Creates a task force to study uncompensated care. Does not provide for MSNJ representation. **No Action.**

AR-139-Hardwick—Medicare Catastrophic Coverage. Requests Congress to find means in addition to beneficiary premiums to fund the Medicare Catastrophic Coverage Act of 1988. **No Action.**

PLACEMENT FILE

The following physicians have written to the Executive Offices of MSNJ seeking information on

possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY

B.E. Shapiro, MD, 4144 Buttercup Ln., Plymouth Meeting, PA 19462. Temple 1985. Board eligible. Available.

Kishorkumar S. Vekaria, MD, 4805 Oxen Ct., Tampa, FL 33624. Baroda (India) 1982 and South Florida 1989. Board eligible. Group, partnership, solo. Available January 1990.

Ricky Zegelstein, MD, 4600 Ninth Ave., Brooklyn, NY 11220. Sackler 1984. Board eligible. Group or partnership. Available.

FAMILY PRACTICE

Leonid Belopolsky, MD, 955 Chanti-

cleer Dr., Cherry Hill, NJ 08003. Moscow 1961. Board certified (ANES). Also, internal medicine. Available.

INTERNAL MEDICINE

Michael G. Donnelly, MD, 10 Overlook Rd., Apt. 4H, Summit, NJ 07901. Medical College of Pennsylvania 1987. Board eligible. Group or partnership. Available.

Charles Neal Jeck, DO, 9273-A Jamison Ave., Philadelphia, PA 19115. Philadelphia Osteopathic 1985. Board eligible. Group. Available.

Leonid Belopolsky, MD, 955 Chanticleer Dr., Cherry Hill, NJ 08003. Moscow 1961. Board certified (ANES). Also, family medicine. Available.

ORTHOPEDICS

D.C. Brown, MD, 2319 Sayre Dr., Princeton, NJ 08540. Available.

UROLOGY

David Altman, MD, 402 Laura Dr., Danville, PA 17821. Jefferson. Board eligible. Available July 1990.

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Category: (Please check one)

☐ Member, MSNJ ☐ Subscriber, NJ Medicine

☐ Other _____

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____



Hahnemann University

DEPARTMENT OF MEDICINE MEDICAL SEMINAR SERIES

WEDNESDAY

8:30A.M.-3:00 P.M.

September 6, 1989

KIDNEY and ELECTROLYTE DISORDERS

Moderators: Charles Swartz, M.D.
Allan B. Schwartz, M.D.

Grand Rounds (8:30 A.M.—Classroom C)
CLINICAL APPLICATIONS of RENAL
PHYSIOLOGY

Clinical Rounds (9:30 A.M.—18th Floor, Hospital)
ELECTROLYTE PROBLEMS

Case Conference (11:00 A.M.—Justan Classroom,
CVI)
PREVENTION of PROGRESSION of KIDNEY
DISEASE

AFTERNOON SEMINAR (12:30-3:00 P.M.)
THE MEANING OF SODIUM: HYPONATREMIA
HYPERNATREMIA
DRUG INDUCED HYPERKALEMIA
CALCIUM and PHOSPHOROUS
MAGNESIUM

Visiting Professor:
Burton Rose, M.D.
Associate Professor of Medicine
Harvard Medical School, Boston MA

September 13, 1989

BONE MARROW TRANSPLANTATION

Moderators: Isadore Brodsky, M.D.
Pamela Crilley, D.O.

Grand Rounds (8:30 A.M.—Classroom C)
GRAFT vs. HOST DISEASE

Bone Marrow Transplant Unit Tour
(9:30 A.M.—15th Floor, Hospital)

Case Conference and Workshop
(10:00 A.M.—Room 8120, College)

AFTERNOON SEMINAR (1:00-4:00 P.M.)
BONE MARROW TRANSPLANT IN AIDS
VENO-OCCLUSIVE DISEASE
FLUID, ELECTROLYTE and
NEPHROTOXICITY COMPLICATIONS
BONE MARROW TRANSPLANT FOR LEUKEMIA
BRONCHIOLITIS OBLITERANS
COMPLICATIONS

BONE MARROW TRANSPLANT FOR
LYMPHOMA
ROLE OF GROWTH FACTORS IN TRANSPLAN

Visiting Professors:
George Santos, M.D.
Professor of Medicine and Oncology
Johns Hopkins University, Baltimore, MD
Rein Saral, M.D.
Associate Professor of Medicine and Oncology
Johns Hopkins Hospital, Baltimore, MD

November 1, 1989

CONGESTIVE HEART FAILURE

Moderators: William S. Frankl, M.D.
Ileana Pina, M.D.
Eric Michelson, M.D.

Grand Rounds (8:30 A.M.—Classroom C)
CONGESTIVE HEART FAILURE:
Therapeutic Approach; when and how!

Clinical Rounds (9:30 A.M.—CCU—21st Floor
Hospital)

Case Conference
TREATMENT OF CHF
Kanu Chatterjee, M.D.
Michael Gheoghiadi, M.D.
Ileana Pina, M.D.
Eric Michelson, M.D.
Ronald Pennock, M.D.

AFTERNOON SEMINAR (12:30-2:30 P.M.)
Classroom C)
NEW DRUGS ON THE HORIZON
DIGOXIN: "REBIRTH of the PHOENIX"
NON-PHARMACOLOGIC APPROACHES
TO CHF
COMBINATION THERAPY OF CHF

Visiting Professors:
Kanu Chatterjee, M.D.
Professor of Medicine
University of California, San Francisco, CA
Michael Gheoghiadi, M.D.
Associate Professor of Medicine, Cardiology
Division, Henry Ford Hospital
Detroit, MI

CONTINUING EDUCATION

CARDIOLOGY

September

- Management of Acute Myocardial Infarction and the Benefits of Thrombolytic Therapy**
9-10:30 A.M.—Board Room, South Amboy Memorial Hospital, South Amboy
(*South Amboy Memorial Hospital*)
- Anti-Arrhythmic Therapy**
7-8 P.M.—Wallkill Valley General Hospital, Sussex
(*AMNJ*)
- Board Review Course in Cardiovascular Disease**
Wyndham Franklin Plaza, Philadelphia, PA
(*Philadelphia Heart Institute, Presbyterian Medical Center, The Graduate Hospital, Council of Clinical Cardiology of the American Heart Association*)

October

- Cardiopulmonary Continuing Medical Education Semi-Annual Program**
4-9 P.M.—Center for Health Affairs, Princeton
(*Breathline, Inc.*)

DERMATOLOGY

October

- Insights into Photochemotherapy and Photobiology**
9 A.M.-5 P.M.—Ramada Renaissance Hotel, East Brunswick
(*UMDNJ-Division of Dermatology*)
- Dermatology 1989**
8 A.M.-4:30 P.M.—Englewood Hospital Medical Center, Englewood
(*Englewood Hospital*)

INFECTIOUS DISEASE

September

- Herpes Simplex Virus in**

Immunocompromised Patients
12 Noon-1 P.M.—Community Medical Center, Toms River
(*Community Medical Center*)

October

- Counseling and Testing for HIV Infection**
4-5 P.M.—South Amboy Memorial Hospital
(*AMNJ and NJDOH*)

MEDICINE

September

- Clinicolegal Correspondence Course**
From September through July 1990
(*MIENJ*)
- Joint Meeting, New Jersey and Pennsylvania Thoracic Societies**
All day, Four Seasons Hotel, Philadelphia
(*New Jersey Thoracic Society*)
- Hepatitis**
7-8 P.M.—Wallkill Valley General Hospital, Sussex
(*AMNJ*)
- Dentistry for the Developmentally Disabled**
1-2 P.M.—Woodbridge Developmental Center, Woodbridge
(*AMNJ*)
- Inotropism: Theoretical Basis, Diagnostic Significance and Therapeutic Implication**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(*St. Joseph's Hospital and Medical Center*)
- What the Primary Physician Must Know and Do To Save Diabetic Legs**
11 A.M.-12 Noon—St. Clare's Riverside Medical Center, Denville
(*AMNJ and NJDOH*)
- Lead Poisoning**
8:30-9:30 A.M.—United Hospitals Medical Center, Newark
(*AMNJ and NJDOH*)

- Board Review Course, Cardiovascular Disease**
Wyndham Franklin Plaza, Philadelphia
(*Philadelphia Heart Institute, Presbyterian Medical Center, The Graduate Hospital, Council of Clinical Cardiology of the American Heart Association*)
- Dually Diagnosed**
11 A.M.-12 Noon—Hunterdon Medical Center, Flemington
(*AMNJ*)

October

- Plasma Lipoproteins, Receptors and Cholesterol Control**
1:30-5:30 P.M.—Drew University, Madison
(*Drew University and CIBA-Geigy*)
- Current Topics in Medical Mycology and Parasitology**
8:30-5 P.M.—Hyatt Regency, New Brunswick
(*Theobald Smith Society and AMNJ*)
- 1989 Eastern Section Meeting of the American Thoracic Society**
8:30 A.M.-6 P.M.—Claridge Hotel and Casino, Atlantic City
(*American Thoracic Society*)
- Techniques for Measuring the Value of a Medical Practice**
1:30-4:30 P.M.—MSNJ Headquarters, Lawrenceville
(*AMNJ and MSNJ*)
- Lyme Disease**
1:30-2:30 P.M.—Hunterdon Medical Center, Flemington
(*AMNJ*)
- Computers in Medicine**
2-3 P.M.—John E. Runnells Hospital of Union County, Berkeley Heights
(*AMNJ*)
- Infections in the Geriatric Population**
10-11:30 A.M.—Marlboro Psychiatric Hospital, Marlboro
(*AMNJ*)

NEW JERSEY MEDICINE is not responsible for last-minute program changes.

THE PHILADELPHIA HEART INSTITUTE

Presbyterian Medical Center

CARDIOLOGY UPDATE

designed for the Physician and provides an intensive survey of the
current status of Clinical Cardiology

WEDNESDAY
SEPTEMBER 6, 1989
3:00 to 5:00 PM

THE MANAGEMENT OF ACUTE MYOCARDIAL INFECTION

MODERATOR: BERNARD L. SEGAL, M.D.

- 3:00-3:30 Thrombolytic therapy in acute myocardial infarction..... *Sol Sherry, M.D.*
- 3:30-4:00 Evaluation of myocardial damage: diagnosis, management,
and prognosis *J. David Ogilby, M.D.*
- 4:00-5:00 Case presentations—Complications of acute myocardial
infarction *Fredric Gerewitz, M.D.*
Panel discussion *Norman Feinsmith, M.D., Garo S. Garibian, M.D.*
Ancil A. Jones, M.D., Robert I. Katz, M.D.,
Henry S. Sawin, M.D.

- No Registration Fee
- Reception following session
- CME Credits*
- Call for Reservation 662-8627

* * *

Scheie Eye Institute Auditorium
Presbyterian Medical Center
39th and Market Streets
Philadelphia, Pennsylvania

Parking Available (at discount rate.)

* * *

*The University of Pennsylvania School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing education for physicians. The University of Pennsylvania School of Medicine designates this continuing medical activity for 2 credit hours per session in Category I of the Physician's Recognition Award of the AMA.

OBSTETRICS AND GYNECOLOGY

October

- Semi-Annual Meeting**
8 A.M.-5 P.M.—Sheraton Poste,
Cherry Hill
(*NJ Obstetrical and
Gynecological Society*)

OCCUPATIONAL MEDICINE

September

- Lead Poisoning**
12 Noon-1 P.M.—St. James
Hospital, Newark
(*AMNJ and NJDOH*)
- Lead Poisoning**
11:45 A.M.-1 P.M.—John F.
Kennedy Medical Center, Edison
(*AMNJ and NJDOH*)

- 1 Occupational Asthma—
Strategies for Treatment and
Prevention in New Jersey**
12 Noon-1 P.M.—Warren
Hospital, Phillipsburg
(*AMNJ and NJDOH*)

- 3 Occupational Asthma—
Strategies for Treatment and
Prevention in New Jersey**
11:30 A.M.-12:30 P.M.—Rahway
Hospital, Rahway
(*AMNJ and NJDOH*)

- 10 Lead Poisoning**
10:30-11:30 A.M.—Saint Mary's
Hospital, Passaic
(*AMNJ and NJDOH*)

- 20 Occupational Asthma—
Strategies for Treatment and
Prevention in New Jersey**
12 Noon-1 P.M.—St. James
Hospital, Newark
(*AMNJ and NJDOH*)

- 21 Lead Poisoning**
11:30 A.M.-12:30 P.M.—Columbus
Hospital, Newark
(*AMNJ and NJDOH*)

- 21 Occupational Asthma—
Strategies for Treatment and
Prevention in New Jersey**
11:45 A.M.-1 P.M.—John F.
Kennedy Medical Center, Edison
(*AMNJ and NJDOH*)

- 22 Occupational Asthma—
Strategies for Treatment and
Prevention in New Jersey**
8:30-9:30 A.M.—United Hospitals
Medical Center, Newark
(*AMNJ and NJDOH*)

- 22 Lead Poisoning**
11:30 A.M.-12:30 P.M.—Overlook
Hospital, Summit
(*AMNJ and NJDOH*)

- 25 Lead Poisoning**
11:30 A.M.-12:30 P.M.—East
Orange General Hospital,

East Orange
(*AMNJ and NJDOH*)

- 27 Occupational Asthma—
Strategies for Treatment and
Prevention in New Jersey**
10:30-11:30 A.M.—Saint Mary's
Hospital, Passaic
(*AMNJ and NJDOH*)

ONCOLOGY

September

- 26 Tumor Conference**
12 Noon-1 P.M.—Community
Medical Center, Toms River
(*Community Medical Center*)

PEDIATRICS

September

- 8 Today's Children, Tomorrow's
Future**
8:30-10:30 A.M.—Hyatt Regency,
New Brunswick
(*NJ Psychiatric Association*)
- 14 Update in Aspects of Pediatrics**
Marriott Hotel, Saddle Brook
(*North NJ Pediatric Society*)

October

- 11 The Dymorphic Child**
9 A.M.-3:30 P.M.—Children's
Specialized Hospital,
Mountainside
(*Children's Specialized Hospital*)
- 19 Pediatric Pulmonary Seminar,
1989**
8:50 A.M.-4 P.M.—Quality Inn,
North Brunswick
(*New Jersey Thoracic Society*)

PSYCHIATRY

September

- 7 Parkinson's Disease**
12 Noon-1 P.M.—Carrier
Foundation, Belle Mead
(*Carrier Foundation*)
- 7 Anxiety Disorders**
1-2 P.M.—Essex County Hospital
Center, Cedar Grove
(*AMNJ*)
- 14 Psychopathology as Predictor of
Treatment Outcome in
Alcoholics**
12 Noon-1 P.M.—Carrier
Foundation, Belle Mead
(*Carrier Foundation*)
- 20 Loneliness: The Pain
and the Prevalence**
All day—Carrier Foundation,
Belle Mead
(*Carrier Foundation*)
- 21 Employee Assistance Programs**
12 Noon-1 P.M.—Carrier
Foundation, Belle Mead
(*Carrier Foundation*)

October

- 2 Medical and Psychiatric
Aspects of Drug and Alcohol
Abuse**
1-2 P.M.—Essex County Hospital
Center, Cedar Grove
(*AMNJ*)
- 5 Urine Drug Testing**
12 Noon-1 P.M.—Carrier
Foundation, Belle Mead
(*Carrier Foundation*)
- 12 Psychiatrists and the Treatment
of Addictions**
12 Noon-1 P.M.—Carrier
Foundation, Belle Mead
(*Carrier Foundation*)
- 19 Female Gamblers**
12 Noon-1 P.M.—Carrier
Foundation, Belle Mead
(*Carrier Foundation*)
- 25 Ethics of Clinical Psychiatry**
All day—Carrier Foundation,
Belle Mead
(*Carrier Foundation*)
- 26 Anxiety Syndromes with
Cardiovascular Symptoms**
11 A.M.-12 Noon—St. Joseph's
Hospital and Medical Center,
Paterson
(*St. Joseph's Hospital and
Medical Center*)

SURGERY AND ITS SPECIALTIES

September

- 11 Surgical Procedures for Chronic
Pancreatitis**
12 Noon-1 P.M.—Hospital Center
at Orange, Orange
(*AMNJ*)
- 14- Interventional Vascular
17 Surgery/Therapy**
6:45 P.M.—Sheraton
Meadowlands Hilton,
East Rutherford
(*AMNJ*)
- 22- A General Surgery
23 Review Course**
7:45 A.M.-4:30 P.M.—Ramada
Renaissance Hotel,
East Brunswick
(*AMNJ and UMDNJ*)

UROLOGY

September

- 13 Related Renal Disease**
10:30-11:30 A.M.—Christ
Hospital, Jersey City
(*AMNJ and NJDOH*)

October

- 11 Urinary Tract Infections**
1:30-2:30 P.M.—Vineland
Developmental Center, Vineland
(*AMNJ*)

THE ACADEMY OF MEDICINE OF NEW JERSEY
and
UMDNJ—NEW JERSEY MEDICAL SCHOOL
DEPARTMENT OF SURGERY
present

**A GENERAL SURGERY
REVIEW COURSE**

Friday, September 22 &
Saturday, September 23, 1989
7:45 A.M. - 4:30 P.M.

at
The Ramada Renaissance Hotel
East Brunswick, New Jersey

This course is designed to give the participant an extensive review of the topics in general surgery and the surgical specialties that are likely to be covered on the American Board of Surgery Recertification Examination as well as the Qualifying (written) Examination of the Board. It also will be of value to the practicing surgeon not studying for either of the examinations who desires an update on general surgery, or for the resident surgeon presently in a training program.

The course is designed to cover the topics from the viewpoint of clinical management and decision making, with basic science considerations added as they enhance the clinical perspective.

The distribution of time allotted to each particular topic will parallel the emphasis given to that topic by the Board in previous examinations.

PROGRAM DIRECTOR: GEORGE W. MACHIEDO, M.D.

Professor and Vice Chairman
Director of Clinical Surgery
UMDNJ University Hospital
Newark, New Jersey

*For Further Information on Registration,
Faculty and Fees, Please Contact:*

Susan E. Weeast
Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, New Jersey 08648
Phone: (609) 896-1717



FINANCIAL STRATEGIES FOR THE 90'S

A Deluxe Seminar Exclusively for the Professional

HAWAII, NOVEMBER 28 TO DECEMBER 5, 1989

\$2098 Per Person,
Double Occupancy

- ★ Keeping More of What You Earn
- ★ The Valuation and Sale of A Practice
- ★ The Why and How of Estate and Retirement Planning
- ★ Tax Shelters What the 1031 Tax Free Exchange Means To You and More
- ★ Make the Tax Laws Work For You
- ★ The Power of Tax Free Income
- ★ Preserving Assets, Tax Credits and Gifts

Package Includes:

Hawaii's Most Elegant Resort Hotels

- 3 Nights Kahala Hilton Hotel
- 4 Nights Mauna Kea Beach Hotel
- New York, Newark, Philadelphia, Hartford, Boston departures
- 4 Group Meetings—2 Dinners, 4 Breakfasts
- Tours, Transfers, Gratuities on Covered Meals and Activities, Taxes
- Seminar Registration Fee additional

Seminar Director:

EUGENE L. STOLER, JD, CPA, LLM

Member of the New York Bar
Adjunct Ass't. Professor of Taxation, LIU Graduate School of Business
Member: Distinguished Faculty Bank of the Foundation for Education, NY State Soc. of CPAs
New Decisions Editor, Journal of Taxation

Mr. Stoler is **NOT** associated with any securities, insurance or other financial instrument sales organization.

ABSOLUTELY NO SALES WILL BE SOLICITED!

Registration Will Be **STRICTLY** Limited For More Personal Interaction

For further information, contact:

CAPITAL SEMINARS, INC.

P.O. Box 224 • Demarest, NJ 07627 • (201) 768-4324

IN MEMORIAM

Gardiner C. Bennett. Retired gynecologist Gardiner Cabell Bennett, MD, died on March 24, 1989. Born in 1919, Dr. Bennett received his medical degree from Albany Medical College, New York, in 1945. A staff member of Overlook Hospital, Summit, Dr. Bennett was a fellow of the American College of Obstetricians and Gynecologists, and was a member of our Union County component and of the AMA. He maintained a private practice in Madison.

Richard J. Bonvicino. Specialist in internal medicine and geriatrics, Richard John Bonvicino, MD, of Paramus, died on April 16, 1989. A 1928 native of New York City, Dr. Bonvicino was graduated from the University of Mexico, Mexico City, in 1958. Dr. Bonvicino was affiliated with Pascack Valley Hospital, Westwood; Bergen Pines County Hospital, Paramus; Meadowlands Hospital Medical Center, Secaucus; Kennedy Memorial Hospital, Saddle Brook; and Harlem Hospital, New York. A fellow of the American Geriatric Society and of the Royal Society of Health, Dr. Bonvicino was a member of the American Board of Quality Assurance and Utilization Review Physicians, of the New York Academy of Sciences, and of our Bergen County component.

Matthew A. Brady. President of the medical staff at St. James Hospital, Newark, where he was attending surgeon for 30 years, Matthew Andrew Brady, MD, died on March 2, 1989. A 1929 Newark

native, Dr. Brady received his medical degree at the University of Zurich Medical School, Switzerland, in 1956. He served his internship and residency at Newark City Hospital and East Orange Veterans Hospital. In addition to his hospital affiliation, Dr. Brady maintained a private surgical practice in Kinnelon, where he resided for 18 years. A fellow of the American College of Surgeons and a diplomate of the American Board of Surgery, Dr. Brady was a member of our Essex County component.

Richard Buffington. Most recently a physician for the Dupont Chambers Works, Deepwater, retired occupational medicine specialist and general surgeon Richard Buffington, MD, died on February 22, 1989, at the age of 60. Born in Pittsburgh, Pennsylvania, Dr. Buffington received his medical degree at the University of Pittsburgh School of Medicine, in 1954. From 1957 to 1959, he served the United States Navy as a lieutenant. Dr. Buffington was a general surgeon in Auburn, New York, from 1961 to 1979, before his employment with Dupont in 1979. A fellow of the American College of Surgeons, Dr. Buffington was a member of the AMA and of our Salem County component.

Louis C. Cartnick. Former Wood-Ridge family physician Louis Charles Cartnick, MD, died on April 1, 1989, at the age of 80. A native of Garfield, Dr. Cartnick earned his medical degree from the University of Vermont, in 1933. In

addition to running a Wood-Ridge practice, Dr. Cartnick maintained affiliations with Hackensack Medical Center and St. Mary's Hospital, Passaic, for 53 years. He served as police surgeon, school physician, and Health Board advisor for the community of Wood-Ridge, before retiring in 1987. Dr. Cartnick was a member of our Bergen County component and of the AMA. He was a 1983 recipient of MSNJ's Golden Merit Award for 50 years of service as a physician.

Edward H. Dyer. Former chief of obstetrics at Atlantic City Hospital and Shore Memorial Hospital, Edward Harvey Dyer, MD, died on April 22, 1989, at the age of 81. Born in Washington, D.C., Dr. Dyer received his medical degree from Georgetown University School of Medicine, Washington, D.C., in 1932. A founding fellow of the American College of Obstetricians and Gynecologists, Dr. Dyer was a member of the Philadelphia Obstetrical Society, of our Atlantic County component, and of the AMA. In 1982, he received the Golden Merit Award from the Medical Society of New Jersey.

Solomon S. Ellenson. Retired Asbury Park pediatrician Solomon Sidney Ellenson, MD, died on March 14, 1989, at the age of 83. Born in Asbury Park, Dr. Ellenson received his medical degree from New York Medical College, in 1930. Affiliated with Monmouth Memorial Hospital, Long Branch, and Jersey Shore Medical Center, Neptune, Dr. Ellenson was a member of our Monmouth County com-

ponent and of the AMA. In 1980, he received the Medical Society of New Jersey's Golden Merit Award, for holding his medical degree for 50 years.

N.J. George. Psychiatrist N.J. George, MD, died on February 12, 1989. Born George John Naduvathusery on November 1, 1933, in India, Dr. George received his medical degree at Kasturba Medical College, Manipal, India, in 1961. He had a private practice in India from 1960 to 1965, before emigrating to the United States. A diplomate in psychiatry and a member of our Cumberland County component, Dr. George was affiliated with Bridgeton Hospital and Newcomb Medical Center, Vineland.

Richard B. Hamilton. A family practitioner from Shrewsbury and Tinton Falls, Richard Bothwell Hamilton, MD, died on April 23, 1989, at the age of 65. Born in Philadelphia in 1923, Dr. Hamilton earned his medical degree at Cornell University Medical College, New York, in 1947. He completed his internship and residency program at Roosevelt Hospital, New York. In 1960, he became a member of our Monmouth County component, and was affiliated with Riverview Medical Center, Red Bank. In addition, he was school physician for Tinton Falls since 1961; a medical consultant at Chemical Dependency Services of Children's Psychiatric Center, Eatontown; and a consulting physician for Emmaus House, Long Branch, and for Tinton Falls First Aid Squad.

Leo Horowitz. Retired in Florida, a radiologist Leo Horowitz, MD, died on March 19, 1989. A 1913 native of Jersey City, Dr. Horowitz received his medical degree from Dalhousie University Faculty of Medicine, Halifax, Nova Scotia, in 1938. A diplomate

in radiology and a fellow of the American College of Radiology, Dr. Horowitz was a member of the North Hudson Physician Society, of our Hudson County component, and of the AMA. He was affiliated with Jersey City Medical Center; Pollack Hospital, Jersey City; and North Hudson Hospital, Weehawken. During World War II, Dr. Horowitz served in the United States army medical corps as first lieutenant. In 1988, he was a recipient of the Golden Merit Award.

James V. Iraggi. Retired specialist in general surgery and obstetrics, James Vincent Iraggi, MD, died on April 3, 1989, at the age of 80. Born in Newark, Dr. Iraggi earned his medical degree in 1935 from the Faculty of Medicine, University of Rome, Italy. A resident of Clifton, Dr. Iraggi maintained a private practice there from 1937 until 1967, when he became director of medical affairs at St. Mary's Hospital, Passaic. A fellow of the American College of Surgeons and of the International College of Surgeons, Dr. Iraggi was a member of the Academy of Medicine of New Jersey, of the Association of Military Surgeons, of our Passaic County component, and of the AMA. He was a captain in the U.S. Army medical corps during World War II. He received MSNJ's Golden Merit Award in 1985.

Thomas M. Kain, Jr. Founder of the Heart Clinic at Cooper Hospital, Camden, in the late 1950s, cardiologist Thomas Michael Kain, Jr, MD, died on March 23, 1989, at the age of 72. Born in Camden, Dr. Kain received his medical degree from Jefferson Medical College of Philadelphia, Pennsylvania, in 1943. From 1949 to 1950, he enrolled in postgraduate studies in medicine at the University of Pennsylvania, followed by a fellowship in cardiology at Jefferson University Hospital, Philadelphia, where he was also an

associate professor of medicine. In 1950, Dr. Kain joined the staff of Cooper Hospital, Camden, where he became chief of medicine, and at the same time, joined his father, Thomas M. Kain, Sr, MD, in private practice. He retired in 1981 after 42 years as a physician in Camden County. A fellow of the American College of Cardiology and of the American College of Physicians, Dr. Kain was a diplomate in internal medicine and was a member of our Camden County component, of the AMA and of the AHA.

Irving Marshall. Retired surgeon Irving Marshall, MD, died on February 27, 1989, at the age of 72. Born in Trenton, Dr. Marshall received his medical degree from Temple University School of Medicine, Pennsylvania, in 1938. He maintained a private practice in Jersey City, where he was a lifelong area resident. Affiliated with Jersey City Medical Center, Dr. Marshall was a faculty member at Seton Hall College of Medicine and Dentistry. A diplomate in surgery and a fellow of the American College of Surgery, Dr. Marshall was a member of our Hudson County component.

Sol Parent. Director of medical education and community medicine at Newark Beth Israel Medical Center, Sol Parent, MD, died on November 3, 1988, at the age of 85. Born in Russia, Dr. Parent received his medical degree at Bellevue Hospital Medical College, New York, in 1928. A specialist in internal medicine and cardiology, Dr. Parent maintained a Newark private practice in addition to serving on the staffs of Newark Beth Israel Medical Center and Saint Michael's Medical Center, both in Newark. A diplomate in internal medicine and a fellow of the American College of Cardiology and of the American College of Physicians.

Dr. Parent was a member of the Academy of Medicine of New Jersey, of the American Heart Association, of the Association of Military Surgeons, of our Essex County component, and of the AMA. During World War II, he was a lieutenant colonel in the U.S. Army air medical corps.

Joseph M. Rampona. Retired internal medicine specialist Joseph Mercer Rampona, MD, died on March 24, 1989, at the age of 89. A Youngstown, Ohio, native, Dr. Rampona received his medical degree from Rush Medical College, University of Chicago, Illinois, in 1933. A Princeton resident since 1936, Dr. Rampona maintained a Princeton practice until his retirement in 1973. Dr. Rampona was a diplomate in internal medicine, as well as a member of the American Heart Association, of the American Diabetic Association, of our Mercer County component, and of the AMA. He was a staff member of The Medical Center at Princeton. During World War II, Dr. Rampona was a lieutenant colonel in the United States Army. Dr. Rampona was a Golden Merit Award recipient in 1983.

John V. Reilly. General surgeon John Vincent Reilly, MD, retired since 1973 in Seaside Park, died on April 1, 1989, at the age of 85. Born in Newark, Dr. Reilly was graduated from the University of Maryland Medical School, in 1929. A Newark surgeon, Dr. Reilly served on the staff of Saint Michael's Medical Center, Newark, for 44 years before retiring. A fellow of the International College of Surgeons, Dr. Reilly was a member of our Essex County component and of the AMA. For 50 years of holding his degree, he received MSNJ's Golden Merit Award. Dr. Reilly was a Coast Guard lieutenant commander during World War II.

Alfred J. Schwager. Retired

chest disease specialist Alfred Joseph Schwager, MD, died on March 14, 1989, at the age of 85. Born in Austria, Dr. Schwager was graduated from the University of Vienna, Austria, in 1929. Affiliated with Mercer Hospital, Trenton, and a fellow of the American College of Chest Physicians, Dr. Schwager was a member of the American Heart Association, of the AMA, and of our Mercer County component. He received MSNJ's Golden Merit Award in 1979.

Vincent A. Scialli. The first board-certified anesthesiologist at Beth Israel Hospital, Passaic, Vincent Antonio Scialli, MD, died on April 14, 1989. A 1915 Jersey City native, Dr. Scialli was a 1939 graduate of Hahnemann Medical School, Philadelphia. Chief of anesthesiology at Beth Israel Hospital from 1959 until 1981 and named president of its medical staff in 1971, Dr. Scialli was clinical consultant in anesthesiology for the New York State Board of Health. A diplomate in anesthesiology, and a fellow of the American College of Anesthesiologists, Dr. Scialli was a member of our Passaic County component.

Archibald D. Sheeran. A specialist in internal medicine at The Medical Center in Princeton, Archibald Daniel Sheeran, MD, died on September 10, 1987. A 1912 New Jersey native, Dr. Sheeran was graduated from Columbia University College of Physicians and Surgeons, New York, in 1943. A diplomate in internal medicine and a fellow of the American College of Physicians, Dr. Sheeran was a member of our Mercer County component and of the AMA. During World War II, he was senior grade lieutenant in the U.S. Navy.

John C. Stillwell. Ewing family physician John Clifford Stillwell, MD, died on March 19, 1989, after 32 years of practice. A 1929 Lin-

coln, North Carolina native, Dr. Stillwell received his medical degree at Jefferson Medical College of Philadelphia, Pennsylvania, in 1955. Affiliated with Helene Fuld Medical Center, Trenton, Dr. Stillwell was a member of the American Academy of Family Physicians, of our Mercer County component, and of the AMA. He was a World War II United States Navy veteran.

Sidney Tucker. Retired physician Sidney Tucker, MD, died on April 19, 1989. Born in 1910 in Perth Amboy, Dr. Tucker received his medical degree from New York University School of Medicine, New York, in 1934; and was licensed in New Jersey in 1938. A pediatrician, Dr. Tucker was associated with Perth Amboy General Hospital, Newark Beth Israel Medical Center, and Babies Hospital, Newark. He was a member of our Middlesex County component and of the American Medical Association. Dr. Tucker practiced in Perth Amboy for 34 years, retiring in 1977. He served as a captain in the Army in World War II, and served with the Columbia Presbyterian Medical Corps in the European Theatre.

Alfred D. Young. Surgeon and internal medicine specialist, Alfred Dennis Young, MD, died on March 17, 1989. A 1919 Newark native, Dr. Young received his medical degree from Columbia University College of Physicians and Surgeons, in 1943. Affiliated with The Mountainside Hospital, Montclair, as well as St. Barnabas Hospital and Presbyterian Hospital, both in Newark, Dr. Young ran a private Montclair office. Dr. Young was a diplomate in surgery and was a member of the Academy of Medicine of New Jersey, of our Essex County component, and of the AMA. During the Second World War, he was a lieutenant, senior grade, in the U.S. Navy.

EDITORIAL CRITERIA

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. All material published is copyrighted by MSNJ.

Content. The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevant to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made to an audience in New Jersey.

Assignment of Copyright. In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statement accompany-

ing material offered to *NEW JERSEY MEDICINE* must contain the following language and must be signed by all authors.

"In consideration of *NEW JERSEY MEDICINE* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *NEW JERSEY MEDICINE*.

Specifications. Submit two manuscripts that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods should be identified.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 30-word abstract.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission must be submitted.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

References should not exceed 5 citations except in review articles and should be cited consecutively by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in numerical order. The style of *NEW JERSEY MEDICINE* is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

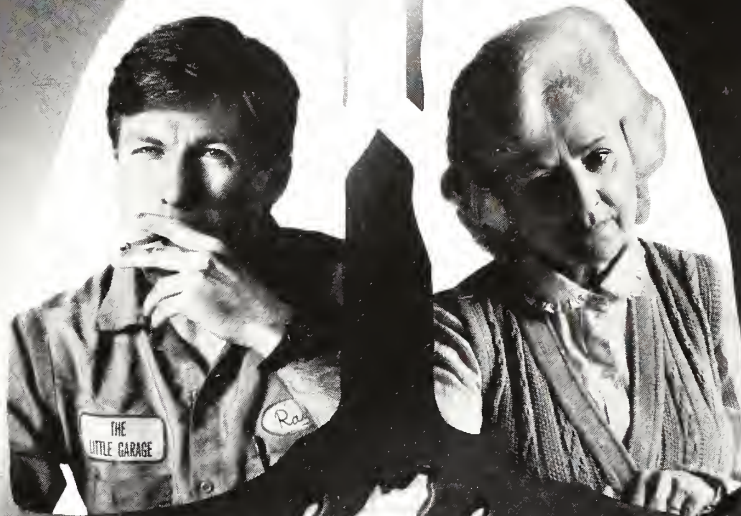
2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

Publication Policy. Receipt of each manuscript will be acknowledged; the paper will be referred to the Editorial Board. The final decision is reserved for the editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. Galley proofs will be submitted to the author for correction.

Reprint Orders. Reprints may be ordered after the author is notified that the article has been selected for a specific issue. A check for the cost of reprints must accompany that order.

Communications. All communications should be sent to the editor, *NEW JERSEY MEDICINE*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

THE LOWER RESPIRATORY TRACT— More vulnerable to infection in smokers and older adults



Experience counts

Ceclor[®]
Pulvules[®]
250 mg
cefaclor

think of it first

For respiratory tract infections due to susceptible strains of indicated organisms.

Summary.

Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in

moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.

- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever). 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
 - As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
 - Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
 - Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.
- Abnormalities in laboratory results of uncertain etiology**
- Slight elevations in hepatic enzymes
 - Transient fluctuations in leukocyte count (especially in infants and children)
 - Abnormal urinalysis, elevations in BUN or serum creatinine
 - Positive direct Coombs' test
 - False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clintest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

Additional information available from
Eli Lilly and Company, Indianapolis, Indiana 46285



Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

© 1988, ELI LILLY AND COMPANY

CE-5012-B-849345



MSNJ NEWSLETTER

MEDICAL WASTE

On June 26, 1989, Governor Kean signed emergency rules regarding medical waste tracking and management. Those rules establish an oppressive and expensive tracking system for health professionals in New Jersey and ignore DEP findings that the sources of medical waste on the beaches lie in the household waste stream.

An expert consultant retained by MSNJ has determined that the \$6 million in fees planned for the medical waste program is 50 percent larger than the fees approved by the New Jersey DEP to fund the solid waste program. Health professionals as small generators are responsible for 10 percent of the medical waste but are being asked to fund 87 percent of the administration's misguided program.

The Medical Society of New Jersey voiced strong opposition to the rule at a public hearing on August 1, 1989, and will file suit if a more equitable and workable plan is not developed.

MALPRACTICE SURCHARGE

The commissioner of insurance has announced a revised rule proposed as suggested by the hearing officer this past winter to fund the \$10 million deficit of the New Jersey Medical Malpractice Reinsurance Association. The Medical Society of New Jersey's opposition resulted in the deficit surcharge proposal being reduced by about \$16 million for physicians never insured by that Association.

The Society still is opposed to the proposal and presented comments in opposition to it at a public hearing on August 22. MSNJ does not expect the commissioner to retreat from his untenable legal position and is prepared to institute litigation.

MEDICARE

The Division of Medical Assistance and Health Services has submitted a proposal concerning presumptive eligibility to the *New Jersey Register*. The proposal indicates that a pregnant woman who is determined presumptively eligible for Medicaid can obtain ambulatory prenatal care from any qualified Medicaid provider. In addition, the proposal indicates that if a pregnant woman loses her eligibility, her entitlement to Medicaid services ends on that date. The prompt termination is in contrast to the regular Medicaid policy of allowing persons to remain eligible until the end of the month. The Division has established a presumptive eligibility hotline for Medicaid providers to verify eligibility when services are rendered. Providers who fail to validate current eligibility risk having their claims denied.

MARCUS WELBY IS ALIVE

A report was presented of data obtained from the Socio-Economic Monitoring System of the AMA and from a study by the American Hospital Association Special Committee on Care for the Indigent at the American Hospital Association 1987 Survey of Hospitals. Physicians are providing an increased amount of care to the disadvantaged who either are indigent or lacking insurance coverage. Currently three out of five physicians provide such care. Physicians are devoting an average of approximately one-half day per week providing charity care and

terms of dollar volume. These figures translate into a \$23,900 reduction in billing by physicians for \$10.8 billion in that year; a \$16,900 net income foregone by physicians for a total of \$6.3 billion for that year.

Data show a majority of physicians provide a free or a reduced charge for care and they have continued to do so even though the financial sacrifice has been increased.

The percentage of all physicians providing uncompensating care is 62 percent—breaking it down to specialties: general—family practice, 64.5 percent; medical, 57.6 percent; and surgical, 65.6 percent. Congressman Stark in his wisdom now is determined to have more doctors leave the practice of medicine because of the 15 percent reduction in fees. Expenditure targets equal rationing for senior citizens and the indigent and uninsured population.

When Dr. Sullivan, chief of Health and Human Services, states that Marcus Welby, MD, is dead, we have news for him! There are many Dr. Welby's alive and practicing medicine.

MORE PRO BONO WORK

"First we kill all the lawyers," is a line from William Shakespeare that is taken very much out of context. Still, there are many of us who feel that way sometimes. Last August, the American Bar Association suggested that lawyers spend more time on public service work. Several states are considering proposals that would require lawyers to give part of their services free to those who need it. Howard Lesnick, a University of Pennsylvania professor, and the man behind this new movement, is concerned because in recent years there has been too much emphasis on law firm profitability. "This is meant to preserve and reinforce a pro bono tradition that goes back a long time," he said. One young woman we know who is attending law school at night confirmed that there is too much greed in law school these days. In truth, there is too much greed in so many occupations. And the University of Pennsylvania Law School is doing something about it. As of next year they are requiring students to spend at least 35 hours of public service legal work during each of their second and third years. Lesnick and the University of Pennsylvania should be congratulated. Law school shouldn't be an ivory tower and perhaps if young law students actually meet and help the needy they may get a whole new look at life. That can't do anything but help future lawyers to carry on their professions in the highest tradition. Now, if the American Medical Association can inspire doctors to give so many hours a year with the needy, it'll be a giant step for mankind. (©Trentonian)

COUNTERPOINT: PRO BONO WORK

Your editorial, "More pro bono work is urged," presented a good discussion until the final paragraph: "Now, if the American Medical Association can inspire doctors to give so many hours a year with the needy, it'll be a giant step for mankind."

How an editorial writer makes such comments without knowing the facts leads to the low esteem that the media, in general, has been receiving. From the time of Hippocrates, doctors gave of their time and energies and expertise to those who needed it regardless of whether they could pay. Every institution gives of its resources to the needy. Almost all doctors do the same.

If the editorial writer had taken the time and listened to Commissioner Molly Coye, physicians of the state gave more than \$500 million of free care last year alone. Those of us involved in teaching programs spend numerous hours coaching the future generation of doctors and not getting

reimbursed. With the high cost of medical education and without the type of assistance, only the very wealthy could afford to become physicians.

Medical students give many hours to the needy under supervision of the "voluntary faculty." Medicaid patients are seen by many physicians who receive below minimal hourly wages for the care they give. Medicaid patients without part B are readily treated also gratis. All major hospitals have clinics for those who do not have the money. My peers and myself deserve an apology. Louis G. Fares, MD

THE UPJOHN COMPANY

The Upjohn Company is seeking to identify potential clinical investigators who have the capability to involve themselves in phase I and phase III clinical projects; the area of research involvement covers all disciplines of medicine and surgery. Interested members should contact Anthony R. Fiore, clinical research associate, 201/766-7243.

CLEARINGHOUSE SPEAKERS BUREAU

The Self-Help Clearinghouse from St. Clares-Riverside Medical Center can provide speakers to give presentations and workshops. Talks can be specialized or general and tailored to the interests of the audience. They serve the entire state and usually talk to groups of 100 or more. Should any members want additional information, please contact Gwen R. Farnsworth, education and outreach coordinator, 201/625-9565.

ISSUING DRUG PRESCRIPTIONS

Did you know that nurses and untrained individuals such as receptionists are prohibited by law from calling in prescriptions to the pharmacist on the physician's behalf? According to state regulation, N.J.A.C. 17:27-7.3(b), only a practitioner may authorize controlled dangerous substance prescriptions to a pharmacist. The law states "A prescription issued by an individual practitioner shall be communicated to a pharmacist by the individual practitioner."

MALPRACTICE PITFALLS

Does your office encourage malpractice? Are you handling irate patients properly? Does your staff jeopardize your office? These questions and others will be answered in a seminar sponsored by the New Jersey Society of Medical Assistants. The program entitled, "How To Avoid the Pitfalls of Malpractice," will be held on Thursday, October 5, 1989, at the Medical Society of New Jersey headquarters in Lawrenceville from 10 A.M. to 3 P.M. For reservations or further information, please contact Linda Wells, CMA, 609/779-1397 or Jamie Brodeur, CMA, 609/893-0741.

SUPPORT SERVICES

A program designed to help physicians cope with the constant exposure to contract proposals and fraud and abuse constraints upon physician business activities will be held in Philadelphia, on October 14 and 15, 1989. This two-day seminar is being presented by Physician Support Services, Inc., and all MSNJ members will receive a 10 percent discount. For more information, contact Mr. Joseph Lucci, MSNJ, 609/896-1766.

SPORTS MEDICINE

"Sports Medicine '89" will be held on October 18, 1989, at the Medical Society of New Jersey headquarters. The program, sponsored by the Committee on Medical Aspects of Sports, will feature two symposia: "Head and Neck Injuries in Sports," and "Anabolic Steroids." Registration opens at 8:15 A.M., and the program begins at 9 A.M. in Lawrenceville. For additional information, call MSNJ, 609/896-1766.

FINI

"There is no medicine like hope, no incentive so great and no tonic so powerful as expectation of something better will happen tomorrow."





PROFESSIONAL LIABILITY

LIABILITY OF AN HMO FOR ACTS OF INDEPENDENT CONTRACTOR PHYSICIANS

In *Boyd versus Albert Einstein Medical Center*,¹ the Superior Court of Pennsylvania held that a patient had a cause of action against a health maintenance organization (HMO) for the malpractice of a participating physician under an ostensible agency theory. Generally, the doctrine of ostensible authority asserts that the principal will be bound by the agent's act, even though the agent acts without actual authority, if the principal has created the appearance that the agent has authority and the third party is unaware of the true limits of the agent's authority. The *Boyd* case may be the first instance of an HMO being held subject to liability for the acts of independent contractor physicians as opposed to employee physicians. The HMO in the *Boyd* case was based on an individual practice association (IPA), and was composed of private practice physicians.

HMOs provide comprehensive health care services to their members in exchange for an all-inclusive fixed rate payment.³ The HMO either employs or contracts with physicians as direct providers of care to its members.⁴ Hospitals and other providers usually are under contract with the HMO to provide institutionally based services, although some HMOs are owned by hospitals.⁵ Unlike traditional indemnity health insurance where insureds receive reimbursement from the insurer for services provided by fee-for-service providers, an HMO pays its providers directly and a member is restricted to using only those providers designated by the HMO.⁶ In this way, an HMO member pays a single premium for health care services, and the HMO in turn directly compensates providers used by the member. Generally, a member is not responsible for payment to individual health care providers for services rendered to them, and the provider agrees to seek payment only from the HMO.

Several factors have contributed to the dramatic growth in plans and membership.⁸⁻¹⁰ First, overall expenditures for health care services as a percentage of the gross national product began to rise appreciably in the mid-1960s, and HMOs were seen as a device to curb these expenditures. Next, consumers began demanding less costly alternatives to traditional health insurance. Finally, increases in the relative number of physicians forced many of them to seek an affiliation with an HMO to insure maintenance of their practice income.¹¹

The surge in the growth of plans was supported by the federal government in the early 1970s.¹² In fact, federal legislation providing venture capital for HMOs resulted in the establishment of 155 new HMOs between 1971 and 1973.¹³ The Nixon administration believed that HMOs could change the fundamentally "perverse incentives" that traditional health insurance gave physicians to hospitalize patients instead of preventing illness by providing preventative medical services.¹⁴

HMOs, like indemnity insurers, bear the risk that the cost of contractual liabilities to their members will be greater than premiums or payments collected. The fundamental difference between the two is that in HMOs physicians contract with the HMO to share part of that risk. Consequently,

ly, most HMOs charge the plan's gatekeeper physicians with the responsibility to authorize expenditures for referral services as well as certain diagnostic and therapeutic procedures. HMO physicians frequently share in any surpluses generated by the plan. This arrangement may create an ethical dilemma for physicians who must balance patient advocacy with the financial incentive to contain costs.¹⁵

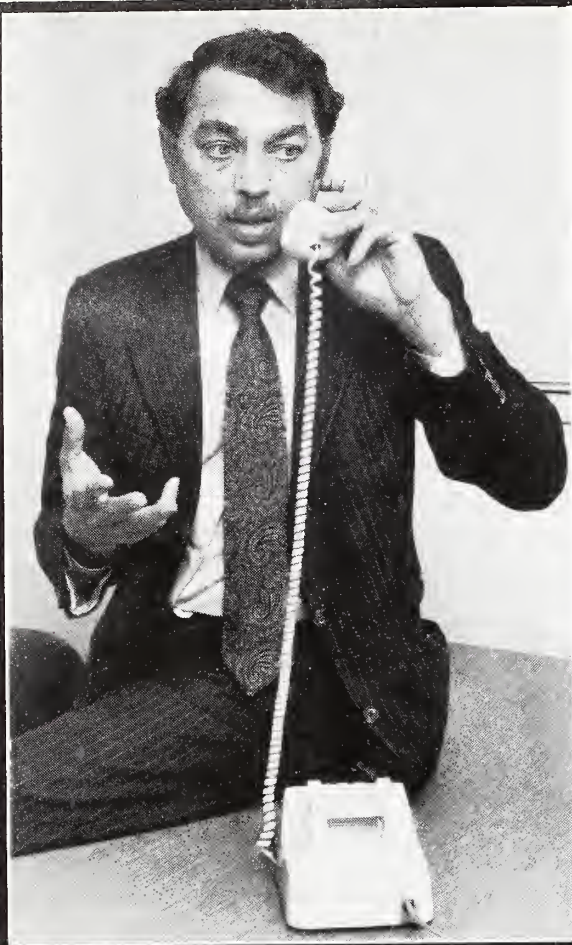
HMOs use other devices to control costs. Most of them combine physician incentives with mandatory participation in the plan's utilization and review program.¹⁶ Typically, this requires the physician to obtain prior approval from the HMO staff for nonemergency hospital admissions. The physician also is in daily contact with the HMO staff while attending a hospitalized patient in order to ensure the services provided are necessary.¹⁷ Physicians may suffer financial penalties or even expulsion from the plan for noncompliance with the utilization review criteria. The HMO has significant control over the practice patterns of nonemployee, independent contractors. This, in turn, suggests that HMOs should be liable for the malpractice of participating physicians.

In *Boyd versus Albert Einstein Medical Center*,¹⁸ the court analogized the liability of the HMO to that of a hospital. This analogy is apt because in both circumstances, the patient may believe the organization employs the physician. In the increasingly competitive environment of the health care industry, HMOs and hospitals both frequently employ media advertising to solicit new subscribers and patients, thereby holding themselves out as providers of care. Other theories which have been employed to hold hospitals liable also may be available to hold HMOs liable. The landmark case of *Darling versus Charleston Memorial Hospital*¹⁹ introduced the doctrine of corporate negligence. In the *Darling* case, the hospital was held liable for the malpractice of an independent contractor emergency room physician. The court held that the hospital had a duty to monitor physicians who provide services to their members. Thus, liability of an HMO could rest on the doctrine of corporate negligence as applied in the *Darling* case. Because HMO members look to the HMO as both the insurer and provider of services, the HMO's duty to its members may be even greater than the hospital's duty to its patient. This is reinforced by the fact that HMO members typically are not permitted to self-refer to specialists of their choice, but rather must rely totally on the HMO and its gatekeeper to arrange for necessary care.

Another potential theory for imposing liability on HMOs is nondelegable duty. Under this theory, the hospital is liable for the malpractice of an independent contractor physician when the services provided are part of the inherent function of the hospital. In *Beeck versus Tucson General Hospital*,²⁰ the court employed this theory to hold the hospital liable for the acts of radiologists who operated the hospital's x-ray department. The *Beeck* case stands for the proposition that when certain inherent functions, essential to the purposes of the hospital, are performed by independent contractor physicians, the hospital may not delegate responsibility for injuries sustained from them.

Physician services are certainly inherent in the functioning of an HMO. In the *Beeck* case, considerable weight was placed on the fact that the patient was not allowed to choose the physician. This also frequently is the situation in HMOs with respect to specialists. Therefore, it may be possible to hold an HMO liable for malpractice of a participating physician under a nondelegable duty rationale.²¹ (*William Stuart, Medical Malpractice Reports, March 1989**)

*Footnote references are available upon request.



"Your patient is doing fine"

When your patient comes to the Eastern Heart Institute for diagnosis or treatment, expect a personal phone call from one of our physicians.

Ongoing communication between the referring doctor and the EHI makes the Institute one of the most physician friendly cardiac care programs in New Jersey. For an appointment to tour our state-of-the-art facility or to receive a brochure, please call.



The
Eastern
Heart
Institute

THE GENERAL HOSPITAL CENTER
at Passaic

350 Boulevard • Passaic • NJ 07055
1-800-432-7834

OFFICES THAT IMPRESS



At W. Berman, we create inspired office environments for small and large businesses alike. Our striking interior designs reflect the distinct character and tastes of our clients—just as they have for over 70 years.

To find out more about W. Berman's special approach to custom office interiors, call us today. Because nothing makes better business sense than a great first impression.

W.Berman

(201) 257-2277
252 Route 18
East Brunswick, NJ 08816



PRESIDENT'S PAGE

MAIL FOR THE PRESIDENT

Nearly every day, my mail contains copies of newspaper or magazine articles from our members. Frequently, these are accompanied by a note saying, in effect, "I assume you have seen this article. . . ." Often, in fact, I have not.

Although I am unable to keep up with all of the New Jersey, New York, and Philadelphia newspapers, I am eager to keep informed about articles on medical issues, brought before the public. I appreciate your thoughtfulness in sending the articles to me.

MEDICINE'S RESPONSE

Some of the articles sent to me are accompanied by a specific or implied request that the Medical Society provide some form of response, perhaps in the form of a letter to the editor of the originating publication. Some of the articles seem to cry out for a strong response from the medical community. For these, the Medical Society of New Jersey is most eager to provide an appropriate response, and will do so.

On other occasions, a response may be inadvisable. Occasionally, the leadership of the Medical Society may decide that the best way to handle an article, or an "attack" on the medical community, is to avoid calling further attention to it. Some battles just cannot be won in the public press. On other occasions, issues may be too complex to deal with in the response format allowed by the publication. Therefore, sometimes, the best response may be no response at all.

When a response does appear to be appropriate, the Medical Society of New Jersey will send it directly to the publication, with a copy to those interested physicians who have called the article to our attention. Keep sending those articles!

CURRENT AFFAIRS

In the fall, the Society will be expanding the information we send to our members, regarding legislation and regulation. There has been a continued demand for this. A separate newsletter currently is under development, to deal on a prompt and timely basis with these issues. During the initial test phase of the new publication, it will be sent to the presidents, presidents-elect, and executive directors of the county and specialty societies, and to all members of our House of Delegates. Within a year, we expect to be able to make this new publication available to any member who requests it. We believe that this additional publication will help to keep our membership better informed, and will enhance the effectiveness of our Society in its efforts regarding public policy.

PHYSICIAN PARTICIPATION

The necessity of physician participation in the determination of public policy, particularly as it affects the health of our patients, has been well recognized by the Medical Society of New Jersey. The current gubernatorial election provides an important means for individual physicians to participate in this political process. In addition to the race for governor, all 80 Assembly seats are up for election. I would urge physicians and their families to participate in the political process in their

communities, work on campaigns, contribute to their favorite candidates, and most importantly, register and vote!

BOARD MEETINGS

If you are interested in getting involved with the activities of the Medical Society of New Jersey, or if you are interested in staying informed about issues that affect the medical community in New Jersey, consider attending the meetings of our Board of Trustees. These meetings, held on the third Sunday of each month, at our executive offices, are open to the entire membership of the Medical Society. Any member can attend. And, any member may participate in the discussion of any topic before the Board. I would encourage all members to attend our meetings on an occasional or regular basis. If you inform our office in advance of your intention to attend, we would be happy to mail a copy of the agenda to you. But, you need not give us any advance notice at all; just show up! We will be happy to see you, and happy to hear from you.

GUEST SPEAKERS

We occasionally have special guests at our Board meetings. Congresswoman Marge Roukema has asked for permission to address our Board at the September 17, 1989, meeting, and has agreed to answer questions from the Board and the audience. Dr. James S. Todd, senior deputy executive vice-president of the AMA, has accepted our invitation to address the Board at the November 19, 1989 meeting. Plan to take advantage of these opportunities.

UNCOMPENSATED CARE

We recently have created a new task force to deal specifically and promptly with the issue of uncompensated care for physician services. Dr. John Baker, a past-president of Atlantic County Medical Society, will be the chairman of this committee.

PRESIDENTIAL INVITATION

Finally, I remain eager to attend your county society and specialty society meetings. Please call our executive offices and invite me to your monthly meetings. □



EDITOR'S DESK

CONTINUING MEDICAL EDUCATION

Who could, or would, argue against the value of continuing medical education (CME), whose entire purpose is to improve the quality of patient care?

During the past generation, the quantum leap in our understanding of human physiology and pathology boggles the mind and almost mandates CME. Books cannot be closed at the end of the medical school curriculum or at the end of residency training; to do so would be to close the mind and to doom oneself to inadequacy as a physician. The practice of medicine involves a lifelong learning experience, even though we can hope only for partial understanding at the end of our journey.

Many states mandate CME credits as a requisite for continued licensure. New Jersey does not demand this, but CME documentation is required for membership in our Society. This is a proper policy, because physicians, as a group, bear responsibility for maintaining and improving the quality of care. This is good peer review.

The venues for CME are many and varied. This issue of *NEW JERSEY MEDICINE* explores some of them. The use of the computer, for example, as an investigative and research tool and as a business machine for the office, is well understood. But its value as a pure teaching instrument may overshadow these other functions in the near future.

Nagging problems do persist. Should a course be taken in conjunction with a vacation to more pleasant climes, conceding that both the learning and the fun may suffer? Should CME be voluntary or mandatory? What is better: individual study programs, self-directed study, or structured lectures or seminars under institutional control? If the latter, what type of review or supervision is needed? Should those who fail to avail themselves of CME suffer a penalty? If so, what kind? More importantly, how does one assess the value of the effort? A few years ago, it was estimated that \$15,000 was being spent per practicing physician per annum in the United States on CME. And this figure did not include travel costs or the loss of income when away from one's practice. Such expenditures of time and money deserve an accounting; unfortunately, the bottom line still proves elusive.

Even so, CME is not only part of our daily professional life, but it deserves to be there. Although residency training and board certification cannot guarantee the competence of the physician, it gives strong evidence of a certain level of accomplishment. Participation in CME, at least, can indicate a strong desire to maintain and to improve one's skills; therefore, it should be encouraged. Meanwhile, we should continue to evaluate, refine, and improve the process.

We are grateful for the efforts being expended on CME in the many programs available in New Jersey. We thank those who contributed so nobly to this issue of *NEW JERSEY MEDICINE*. We especially are grateful to our guest editors, Drs. Lippman and Thorpe. □

WHERE DO THEY GO WHEN YOU
TELL THEM TO LOSE WEIGHT?
TREAT THEM IN YOUR OFFICE



Nutri-Lene

State-Of-The-Art Supplemented Fasting Program

- Safe
- Medically Proven
- Simple
- Effective
- No Calorie Counting
- No Weighing Food
- No Measuring Food
- No Gimmicks
- No Shipping Costs
- Economical
- Convenient
- Sold To Physicians Only
- Physician Owned Company

For information, samples, or a free tutorial, call: 201-712-0909 or 800-333-9399. Medical Weight Management, Inc., 441 Market Street, Saddle Brook, N.J. 07662.

MEDICAL MANAGEMENT

From One Specialist
To Another
The Physician's Consultant

Mary Ann Hamburger, Associates

74 Hudson Ave., Maplewood, New Jersey 07040

201-763-7394

Are you spending more than
\$200/year

on Medical Waste Removal?

If you are a small generator

CALL

1-800-447-0026

Doctors Disposal Service Inc.

Licensed by the State of NJ,

is accepting new accounts

*Medicalstructures**

DESIGNERS-ARCHITECTS-BUILDERS

NEW JERSEY'S FOREMOST
BUILDERS OF WALK-IN
MEDICAL FACILITIES & OFFICES
COMPLETE DESIGN,
ARCHITECTURE & FINISHED
CONSTRUCTION IN A SINGLE
WORRY-FREE PACKAGE.

FOR FURTHER INFORMATION
AND REFERENCES—PHONE
TOLL FREE

1-800-325-2160

* A DIVISION OF

J.S. HARPER CO.

2430 E. LINDEN AVE.

LINDEN, N.J. 07036

DEBTS COLLECTED

*by PROFESSIONALS
for PROFESSIONALS*

Deal directly with the Law offices of

SOL ROSENBERG P.A.

366 Clifton Ave.

P.O. Box 1325

Clifton, N.J. 07105

INQUIRIES INVITED

Phone (201) 340-2800

Fax (201) 340-2807

*35 Years experience
in medical collections*

References upon request.



BOOK REVIEWS

ETHICAL ISSUES AT THE ONSET OF LIFE

William B. Weil, Jr, and Martin Benjamin (eds). Boston, MA, Blackwell Scientific Publications, 1987. A team of thoughtful professionals, with knowledge in more than one area of genetics, medicine, ethics, and the humanities, informs us of the personal and societal issues inextricably interwoven in clinical research and medicine at the outset of life. The authors present concise facts about in vitro fertilization, gestation, in utero fetal surgical and medical therapy, as well as problems during the perinatal period.

While the technological imperative creates that which is possible, the writers relentlessly question what is good and what is bad. They pose practical questions reaching into an individual's adult life. For example, what protection does an individual have if there is a possible discrimination due to knowledge of genetic variation that may put the individual at risk?

The text discusses abortion from the perspective of the individuals actually involved in the process: the mother, the fetus, and the physician. The author stresses that the woman's perspective has helped physicians understand that abortion involves a decision of "one profoundly undesirable outcome over another undesirable outcome." They confront issues such as the rights of a mother to refuse in utero surgery on the fetus, or to refuse a cesarean section, especially recognizing that the climate of malpractice may unconsciously move the obstetrician toward too liberal a criterion for surgery. The chapter on perinatal ethics in anthropological perspective expands the dialogue and underscores the role of myth and belief as it influences emotions which, in turn, profoundly influence reasoned decisions.

The authors forthrightly analyze the somewhat mistaken notion that doctors do not make quality of life decisions. In this manner, they strip the physician of his armor. In order to clarify vague issues, the authors do not hesitate to commit themselves to a particular position presented in the text.

The notion of "compromise" is examined in the context of a society based on the principles of independence and choice, but made up of individuals with radically different world views.

The final chapter on ethics and social policy fails to go far enough to stress the need for increased public input into policy decisions through vehicles of commissions, health decisions assemblies, citizens' groups, and ethics committees. The authors of *Ethical Issues at the Onset of Life* have succeeded admirably in presenting a broad and balanced treatise on which future issues can be analyzed. Don't miss this book.

□ Joseph F. Fennelly, MD

IMMUNOLOGY OF THE EAR

Joel M. Bernstein, MD, PhD, and Pearay L. Ogra, MD (eds). New York, NY, Raven Press, 1989. This is an exceptional book which should be in the library of all laryngologists, pediatricians, and internists involved with infectious disease. As the name of the book implies, this is an

absolutely complete treatise on the subject, with great detail in basic science as well as clinical manifestations of the immune system. The book covers much more than immunology of the ear; there are sections on physiopathology of the eustachian tubes as well as immunology of the tonsils and adenoids. The strong points of this text are the various chapters written by experts in the field. The chapters on bacteriology and virology are complete. Therefore, this book with the simple name *Immunology of the Ear*, fills the void in most practitioners' knowledge about the immune system of the head and neck area. The references are complete. It is my recommendation that this book be part of most libraries. □ Harold Arlen, MD

MOLECULAR BIOLOGY OF THE CELL

Bruce Alberts, Dennis Bray, Julian Lewis, et al. New York, NY, Garland Publishing, Inc., 1989. *Molecular Biology of the Cell* represents a comprehensive, enormously interesting, college textbook in modern cell biology. The text is divided into three sections: "Introduction to the Cell"; "Molecular Organization of Cells"; "From Cells to Multicellular Organisms." Excellent diagrams complement the text so that complex interactions among various subcellular constituents are made clear. The authors have managed to write an introductory and a general reference text. Each chapter contains numerous references; one can gain access to the original literature pertaining to a specific topic, according to an individual's interest. The last section contains chapters on fertilization, development, differentiation, the immune system, the nervous system, special aspects of plant cells, and cancer. The chapter on cancer gives a readable and current review of cancer cell biology and the molecular genetics of cancer—including a discussion of oncogenes. The era of biotechnology is upon us and we are fortunate that such a comprehensive book is available to keep us up to date. □ Jonathan Yavelow, PhD

MOLECULAR BIOLOGY OF THE CELL. THE PROBLEMS BOOK

John Wilson and Tim Hunt. New York, NY, Garland Publishing, Inc., 1989. *The Problems Book* enables students to test their own knowledge and, perhaps more importantly, presents a problems approach to cell and molecular biology. In other words, experimental results and methods are presented in order for the student to learn the thinking that enables the development of various facts about cell biology. *The Problems Book* enables the student to critically learn the subject without interrupting the flow of narrative in the text. *Molecular Biology of the Cell* and *The Problems Book* represent opportunities for doctors and health care workers to share the fascination and importance of modern cell biology. □ Jonathan Yavelow, PhD

PRIMER OF DERMATOPATHOLOGY

A.F. Hood, MD, T.H. Kwan, MD, D.C. Burnes, MD, M.C. Mihm, Jr., MD. Boston, MA, Little, Brown & Co., 1984. This softcover, glossypaged book is precisely what its title proclaims. It presents a sympathetic approach to the differential diagnosis of microscopic sections of most skin diseases. The reader is instructed how to examine the material on the slide and how to recognize and how to categorize patterns of abnormality. The book then is arranged in chapters and sections which correspond to major morphologic characteristics, e.g. epidermis—vesicles and bullae, hyperplasias, atrophies, dermis—perivascular infiltrates, upper or reticular dermis, diffuse infiltrates. Conditions and diseases are described in lists of diagnostic features rather than in narrative style. Accompanying black-and-white photomicrographs, and very useful line drawings demonstrate representative findings. There are very few comments related to the clinical condition, rather, the reader is provided a list of selected references at the end of each chapter. The book will be a helpful lamp for those taking their first unsure steps into the mysterious terrain of dermatopathology. □ Christopher M. Papa, MD

CME

**Pages 681,
726-731**

30 Years of Experience

G.P. Connors & Associates

John J. Kubik Associates

Consultants To The Healthcare Industry

**BUSINESS SERVICES TO
MEDICAL PROFESSIONALS**

- Managerial Reviews and Counsel
- ICD-9 and CPT Coding
- Personnel and Organizational Development
- Marketing and Business Plans
- Partnership Structures
- Accounts Receivable Reduction Programs
- Billing Operations Review
- Hospital Joint Ventures
- Practice Management
- Practice Valuations
- Fee Schedule Analysis
- Medicare Compliance Reviews

16 Welland Rd. • Hamilton Square, NJ 08690 • (609) 587-7177
RD3 Box 64 • Freehold, NJ 07728 • (201) 431-3847

**Our Semi-Annual
Cardiopulmonary Continuing
Medical Education Program**

BreathLine

An Educational Affiliate of
The Breathing Centers

*Keeping
You
Informed*

Breathline is proud to present **Breathline Seminars**, an ongoing medical education program planned for internists, pulmonologists, cardiologists, allergists, respiratory therapists, cardiopulmonary nurses and technicians and pharmacists.

We invite all New Jersey physicians and health professionals to attend this informative event to be held on Tuesday, October 10, 1989 from 4 to 9 p.m. at the **Center for Health Affairs** in Princeton, NJ. Topics to be discussed include:

- ◆ Nocturnal Hypoventilation Syndromes
 - Spectrum of disorders
 - Post Polio Syndrome
 - Neuromuscular disorders
 - Other neuromuscular and skeletal abnormalities
- ◆ Evaluations and treatment of Nocturnal Hypoventilation Syndromes
- ◆ Nocturnal Respiratory Disorders
 - Sleep Apnea/Diagnostic Options
 - Sleep Apnea/Treatment Options
- ◆ Evaluation of Dyspnea and Exercise Limitations
- ◆ Update on pulmonary rehabilitation
 - Pulmonary rehab: an overview
 - Objectives of rehab programs

Dinner is included in the registration price. CME credits available. For a complete list of speakers and registration information, call the Breathline at 1-800-634-5864. Registration deadline: October 2, 1989.

What's So Special About CME?

This special issue of NEW JERSEY MEDICINE is dedicated to the why and how of continuing medical education (CME), with the focus clearly on what is happening here in our home state and what opportunities are available conveniently so that continuing medical education can be accomplished efficiently and nonintrusively for the benefit of ourselves and for patients under our care.

Why do we need CME? Because of the rapidity with which advances occur in the modern practice of medicine, physicians are challenged daily to update knowledge and skills. CME is the method by which proficiency and professional standards are maintained and upgraded.

What CME is available? CME opportunities in New Jersey are nearly ubiquitous. Formal lectures and conferences occur daily in virtually all hospitals and health care establishments. Local and regional publicity inform physicians through regular event calendars calling attention to programs all over the state.

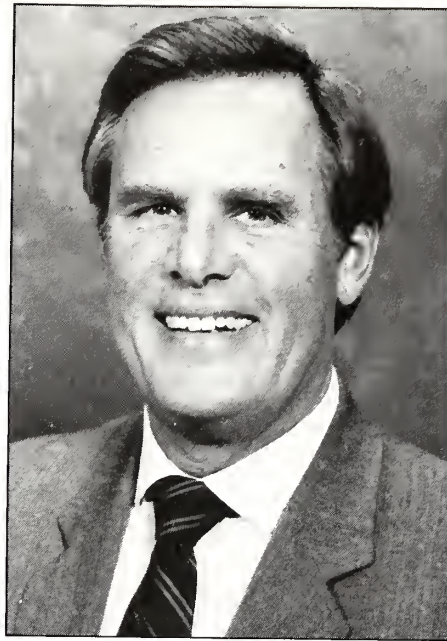
Because much of a physician's CME activities are self-directed, opportunities abound for making use of a variety of personal, individualized CME methods. Innumerable travel-study programs provide the opportunity to combine relaxation and time away from daily obligations with learning and relearning. Keeping up with the nearly overwhelming amount of material provided in regularly published medical journals is widely acknowledged as a nearly insurmountable task. This has led to the establishment of numerous journal abstract services which serve to focus and distill the vast amount of information provided daily. Journal clubs can provide the opportunity to interact with others in order to amplify understanding and enhance relevance. Newer, "state of the art" technology in the form of audiovisual techniques, interactive computer programs, and other special programs serve to round out the variety of ways that CME can be made immediate and relevant.

How can one make use of CME? By now, you probably know your own individual learning style. Whether you absorb more from reading, listening, doing, or teaching—or a combination—every method and technique is available within New Jersey.

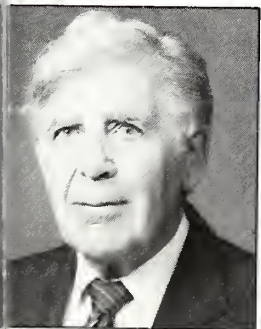
**Alan J. Lippman, MD
James H. Thorpe, MD**



Alan J. Lippman, MD



James H. Thorpe, MD



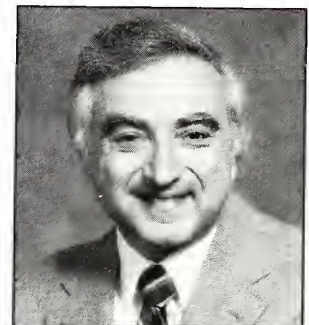
Alfred A. Alessi, MD



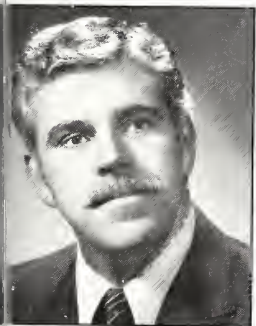
Ronnie Davidson, EdD



Richard E. Dixon, MD



Richard K. Goodstein, MD



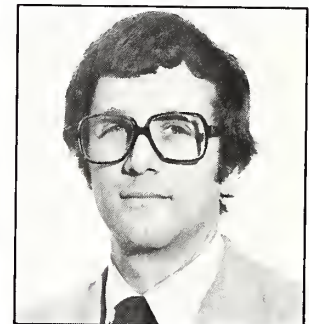
Charles J. Heitzmann



Robert Heller



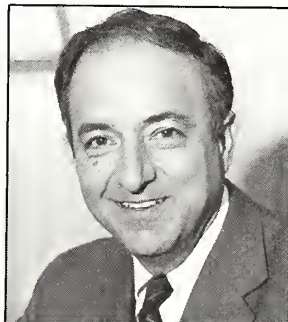
Martin E. Johnson



Steven M. Marcus, MD



Robert R. Moutrie, PhD



Louis Scibetta



William S. Vaun, MD



Steven F. Wang, MD

**Entrepreneurs
& professionals
often need
to take a fresh
look at their
own business...**



Rita Ben-Ami
Business Management Services

We offer new
perspectives and alternatives
for growth and management

Ben-Ami Inc.
63 Ash Street, Englewood Cliffs, NJ 07632
201/569-0616



**Professional
Financial Advice
Need Not Be Expensive
UNLESS ...
You Don't Have It**

**We are
"Registered Investment Advisors"
personally involved in
advising physicians since 1971**

**Authorized Representatives for
M.S.N.J. Endorsed Section 419 Plans**

*No Fee For Initial Consultation
No Fee For Exploratory Meetings*

Kirwan Financial Advisory, Inc.

609-778-4388

215-750-7616

PRACTICE MANAGEMENT VENDORS

Accumedic	1-212-736-09
Annon Systems, Inc.	1-312-564-83
CALYX	1-800-558-22
CYMA/Worldwide Technologies, Inc.	1-800-292-29
Data Strategies, Inc.	1-619-451-04
GSR Systems, Inc.	1-800-426-94
Healthcare Communications	1-402-489-02
Mid-Atlantic ICS, Inc.	1-800-366-21
PRISM Data Systems	1-800-223-38
ProVision, Inc.	1-800-772-28
RLI Professional Technologies, Inc.	1-800-447-22
Santiago Data Systems, Inc.	1-800-652-35
The Cactus Medical Group, LTD.	1-800-876-94
UNIVAIR, Inc.	1-314-426-10
Westland Software House, Inc.	1-800-423-58

CLAIMS ONLY VENDORS

Mid-Atlantic ICS, Inc.	1-800-366-21
Santiago Data Systems, Inc.	1-800-876-35

SERVICE BUREAUS

Control-O-Fax	1-319-234-46
Also Service by:	
Mifax Service and Systems	
Creative Systems	
Systems and Services	

's The Last of The Month . . . o You Know Where Your Claims Are?



Submitting your claims electronically is faster, more error-free, and more cost-effective. Our **EMC*EXPRESS™** system is the electronic solution, eliminating your paper intensive environment.

- Minimize time for preparation of claims
- Computerized editing of claims virtually eliminates suspended or rejected claims
- No mail delays
- No re-keying of claims by carrier
- Faster claim reimbursement
- Claims to over 100 insurance companies

For more information, contact one of the vendors listed.

EMC*EXPRESS™

GTE Health Systems

301•217•5500

Continuing Medical Education

JAMES H. THORPE, MD

Continuing medical education (CME) is more highly organized in the United States than anywhere else in the world. The history of its development has been chronicled.¹ An excellent overview of the current state of the art of CME as it exists in the United States today is provided in a recent issue of the *Journal of the American Medical Association*.²

Organizations acting as sponsors for CME programs endeavor to adhere to certain nationally recognized standards. These so-called "seven essentials" (Table 1) are guidelines for formal postgraduate medical educational activities. Other health professions have crafted their continuing education activities using similar codes, along with parallel mechanisms for accreditation and certification.³

Dr. Thorpe, a medical education consultant, is a member of the ACCME Review Committee and a former CME surveyor for MSNJ. Requests for reprints may be addressed to Dr. Thorpe, 78 Twin Oaks Avenue, San Rafael, CA 94901-1916.

ACCME. Responsibility for maintenance of CME standards belongs to the Accreditation Council for Continuing Medical Education (ACCME), which is composed of seven professionally interrelated policymaking members (Table 2). These groups represent all of the major components of medical education and licensing bodies, including academia and clinical practice. Through its various committees, ACCME is responsible for program evaluation and for the award of accreditation recognition to more than 700 medical schools and other educational institutions, as well as to 45 state medical associations which in turn serve as regional accreditors.

CME in New Jersey. At the state level, accrediting and accredited CME agencies both exist. In New Jersey, the Medical Society of New Jersey is ACCME approved and, in turn, acts as an accreditor for institutions within the state. Such recognition enables the hospitals to award category CME credits to physicians attending activities that meet the state's standards.⁴

The Academy of Medicine of New Jersey and

Table 1. The seven CME essentials.

1. The sponsor shall have a written statement of its continuing medical education mission, formally approved by its governing body.
2. The sponsor shall have established procedures for identifying and analyzing continuing medical education needs and interests of program participants.
3. The sponsor shall have explicit objectives for each CME activity.
4. The sponsor shall design and implement educational activities consistent in content and method with the stated objectives.
5. The sponsor shall evaluate the effectiveness of its overall continuing medical education program and component activities, and use this information in its CME planning.
6. The sponsor shall provide evidence that management procedures and other necessary resources are available and effectively used to fulfill its continuing medical education mission.
7. The sponsor shall accept responsibility that the essentials are met by educational activities which it jointly sponsors with nonaccredited entities.

Table 2. ACCME composition.

- American Board of Medical Specialties (ABMS)**
One American Plaza—Suite 805, Evanston, IL 60201
(312) 491-9091
- American Hospital Association (AHA)**
840 North Lake Shore Drive, Chicago, IL 60611
(312) 280-6000
- American Medical Association (AMA)**
535 North Dearborn Street, Chicago, IL 60610
(312) 645-5000
- Association for Hospital Medical Education (AHME)**
1101 Connecticut Avenue NW—Suite 700,
Washington, DC 20036
(202) 857-1196
- Association of American Medical Colleges (AAMC)**
One DuPont Circle NW—Suite 200,
Washington, DC 20036
(202) 828-0460
- Council of Medical Specialty Societies (CMSS)**
P.O. Box 70, Lake Forest, IL 60045
(312) 295-3456
- Federation of State Medical Boards (FSMB)**
2630 West Freeway—Suite 138, Fort Worth, TX 76102
(817) 335-1141

branches of the medical school are accredited by ACCME as purveyors of CME activities. These groups may produce their own programs, granting

category 1 CME credits, or jointly sponsor activities with nonaccredited groups. Again, all formal CME must meet stated standards in order to carry the familiar accreditation statement seen in publicity brochures.

The Community Level. At the community hospital, often the center for CME activities for health care practitioners, educational activities may be specifically designed to answer the current needs of the particular staff. Programs may relate to hospital-specific needs, to the latest diagnostic and therapeutic services, and to the unique requirements of practice within that institution. In many hospitals, such CME activities may be supervised by a director of medical education (DME), sometimes referred to as a CMeducator.

New Technologies. Today's CME scene, apart from traditional and customary teaching programs, is supplemented by a remarkable number of innovative new educational techniques, including audiovisual materials, cable television methodologies, and various computer applications. Many of these innovations represent ways of promoting more self-directed learning opportunities for busy practitioners unable to set aside separate time commitments to participate in more formal programs. Outgrowths of these technologies are special programs assisting DMEs and CMeducators to improve their skills, helping them to practice what they preach. Several components of ACCME, such as the Association for Hospital Medical Education (AHME), provide their own publications and regional affiliates. For example, AHME-NJ conducts its own local meetings and symposia to promote effective educational methods.

Enforcement of CME. While the importance of CME in the maintenance of competency in medical care is widely recognized, opinions vary as to whether such activities should be regarded as mandatory or voluntary, and how best to assess quality and effectiveness of programs. Other issues relate to methods for quantifying the value of self-directed CME activities and the relationship such activities should have to other, formalized programs.

American CME has grown to early maturity but continues to evolve, setting an example to organized medicine in other nations and providing benefits to practitioners and patients throughout the country and here in New Jersey.⁵ ■

REFERENCES

1. Richards RK: *Continuing Medical Education: Perspectives, Problems, Prognosis*. New Haven, CT, Yale University Press, 1978.
2. Osteen AM, Gannon MI: Continuing medical education. *JAMA* 282:1105, 1989.
3. Green JS, Grosswald SJ, Suter E, Walthall DB (eds): *Continuing Education for the Health Professions*. San Francisco, CA, Jossey-Bass, 1984.
4. Rosoff AB, Felch WC (eds): *Continuing Medical Education: A Primer*. New York, NY, Praeger, 1986.
5. Manning PR, DeBaKey L: *Medicine: Preserving the Passion*. New York, NY, Springer-Verlag, 1987.

CME and MSNJ

BERNARDO TORO-ECHAGUE, MD
MARTIN E. JOHNSON

The Medical Society of New Jersey, through its standing Committee on Medical Education, conducts a number of essential functions in support of continuing medical education (CME) in the state. The Education Committee currently is composed of 12 members and 4 consultants. Of the 12 members, 9 members are appointed by the president of MSNJ and 3 members are elected by the House of Delegates. Both the Academy of Medicine of New Jersey and the University of Medicine and Dentistry of New Jersey are represented.

A major function of the Education Committee is to participate in hospital and institutional surveys and to review CME programs. The Committee also functions as a coordinator of special events programs and may act as cosponsor for special interest programs including such topics as tobacco, drug abuse, and AIDS.

MSNJ accredits CME programs meeting the criteria for accreditation of the Accreditation Council for Continuing Medical Education (ACCME). The Education Committee is certified by ACCME as the sole entity to accredit New Jersey community hospitals and institutions to ensure their capability of delivering CME category 1 credit in compliance with nationally approved standards.

ACCREDITATION STANDARDS

In order to assure national acceptance of MSNJ accreditation, MSNJ has adopted the standards known as "Essentials for Accreditation of Continuing Medical Education," used by the ACCME. The Education Committee has established the following

Dr. Toro-Echague is chairman, MSNJ Committee on Education and Mr. Johnson is director of medical education, Medical Society of New Jersey. Requests for reprints may be addressed to Mr. Johnson, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

goals for its accreditation program: 1. The director of medical education (DMEs) and the Committee on Medical Education understand the "Essentials" of the process, and the principles behind them. 2. Those organizations and institutions which offer CME can realistically provide "quality" educational programs. 3. Those institutions and organizations that are accredited are accomplishing their goals.

Mechanics for accomplishing these goals involve: 1. Producing and disseminating information regarding the essentials and guidelines with explanation of the meaning of the standards by publications, workshops for DMEs and personnel, letters, telephone contacts, and individual consultations. 2. Encouraging and supporting accredited institutions and organizations through workshops and by means of the CME manual, a publication of the Education Committee. 3. Making the survey and accreditation process available within a reasonable time frame and at the least possible expense. 4. Providing advice, recommendations, and informing DMEs of any changes in standards.

Quality assurance that standards are maintained is provided through periodic documentation through the mechanism of annual status reports outlining program content, specific objectives, personnel, and appropriate evaluation criteria.

In most cases, quality CME activities require suitable hospital administrative support in order to provide suitable facilities, equipment, and resources to enable programs to succeed. Approximately 75 percent of the eligible community hospitals in New Jersey have been approved by MSNJ for conducting category 1 CME programs. This is well above national averages.

MSNJ AND AMNJ

The educational arm of the MSNJ is the Academy of Medical and Natural Sciences (AMNJ).

of Medicine of New Jersey. The Academy initiates programs and coordinates educational activities of many sorts. It operates, in part, under a grant from MSNJ to assist in underwriting its operations and, in addition, MSNJ also cosponsors and provides funding for such programs that it requests the Academy to organize. There exists excellent cooperation and good working relationships between MSNJ and the Academy through conjoint committee meetings and cosponsorship of meetings and conferences.

LIAISON WITH OTHER GROUPS

MSNJ maintains close working relationships with the American Medical Association through its Council on Medical Education and ACCME. For those New Jersey physicians who chose not to be members of the parent AMA, MSNJ offers an identical physician's recognition award to acknowledge the continuing education efforts of its own membership.

Publicity for CME activities provided for or in any way cosponsored by MSNJ is provided through *NEW JERSEY MEDICINE*, the journal of the Medical Society of New Jersey.

MSNJ cooperates, in addition, with other important groups throughout the state, including the New Jersey State Department of Health, the New Jersey Hospital Association, and the University of Medicine and Dentistry of New Jersey, providing a highly productive network of activity in promotion of quality CME for the state's physicians.

PHYSICIAN'S RECOGNITION AWARD

Nine state medical societies, including New Jersey, require documentary evidence of maintenance of CME for membership and six of these states, again including New Jersey, accept the physician's recognition award (PRA) as fulfilling this requirement.

The PRA was established by the House of Delegates of the AMA in 1968 to recognize physicians who have participated in various CME activities. Recognizing physicians learn in different ways, the AMA acknowledges a variety of educational methods as acceptable for physicians to qualify for the award. Until 1986, six categories of education were recognized. These included attending lectures and demonstrations, reading and other forms of self-study, teaching and publishing journal articles, and research reports. A final category allowed the inclusion of "other meritorious activities" that did not fall into any of the other five categories.

The first category, known as "category 1" is characterized by the fact that activities designated as category 1 have been recognized as having been credited by organizations, such as ACCME, MSNJ, and AMNJ, and educational institutions

which can ensure that the programs they recognize fulfill certain criteria. These criteria include: conformation with the AMA's definition of CME, provision for meeting specific educational needs, assurance that program content is appropriate suitable methodology, mechanisms for evaluating the quality and relevance of the activity, and appropriate means of documentation of physicians' participation. Educational activities included in this category include such learning experiences as grand rounds, seminars, workshops, teaching rounds, departmental scientific meetings, clinical traineeships, mini-residencies, and scientific sessions of medical and medical specialty societies including local, regional, state, national, and international meetings. Included also in this category are such activities as visiting lecture programs, CME courses, accredited correspondence courses, and self-assessment programs. Accredited audio-visual programs also are recognized, provided that there is a local instructor who conducts or supervises the learning experience and supplements the teaching as required to answer local needs.

The *Journal of the American Medical Association* publishes annually in August a special educational issue listing many sponsors and programs fulfilling category 1 requirements. *NEW JERSEY MEDICINE* likewise provides such information statewide in its regularly scheduled monthly issues.

Since 1986, the original six educational categories have been simplified for reporting purposes. At the present time, two categories are recognized, category 1, which remains as described, and category 2, which encompasses all of the other categories previously described which, while meritorious, lack specific accreditation provisions at this time. The entire procedure remains at this time evolving, and it may be anticipated that further revisions will be forthcoming in order to keep pace with changing needs in the entire spectrum of CME.

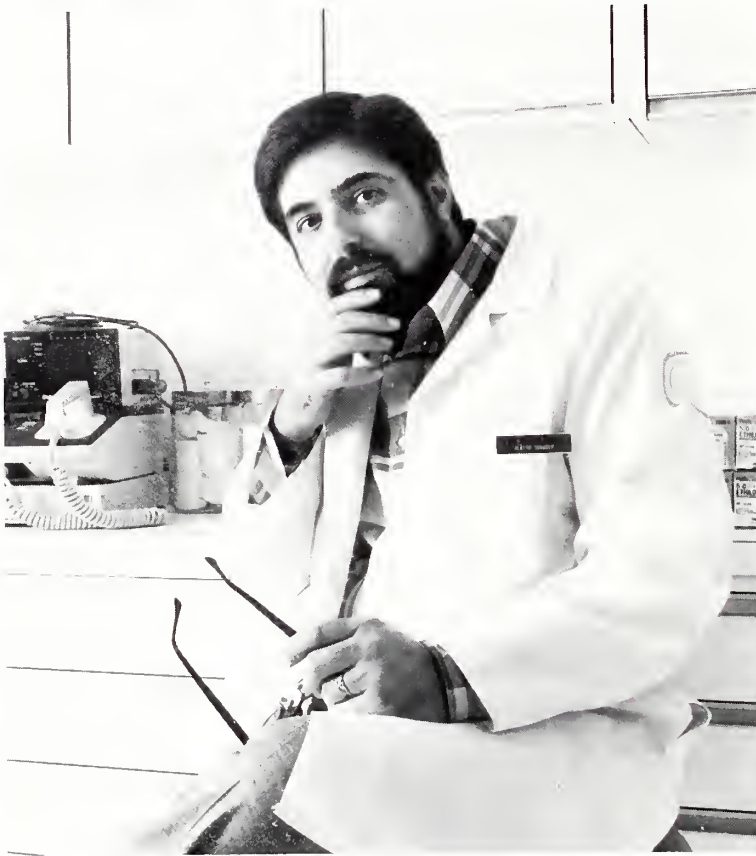
MANDATORY CME LEGISLATION

At the present time, 27 states and the District of Columbia have adopted legislation mandating certain requirements for CME in order to obtain or to maintain medical licensure. Eleven states will accept the PRA as evidence for proper maintenance of CME activities.

In New Jersey, such legislation has not yet been adopted, but has been under serious consideration. The Joint Committee of the New Jersey State Board of Higher Education and the New Jersey State Board of Medical Examiners are on record as advocating this move. The assumption behind this reasoning is that medical doctors should not be licensed for life and that continuing education is essential for maintaining practice skills. ■

**“A big insurance company
that helps me build my practice?”**

**I don't
believe it.”**



AMNJ: A Commitment to Education

ALFRED A. ALESSI, MD
RONNIE DAVIDSON, EdD
CHARLES J. HEITZMANN

Established in 1911, the Academy of Medicine of New Jersey (AMNJ) has long represented the commitment of conscientious medical and dental practitioners to professional excellence through education. AMNJ was founded as an educational organization to fill a void in northern New Jersey in the postgraduate education of our physicians. The Academy's role increased significantly at the end of World War II; returning physicians from the service felt there was a gap in their medical knowledge as a result of a long hiatus from civilian medicine. The Academy remedied this by coordinating refresher courses for the returning veterans in all the specialties. There were no fees for the returnees and no honoraria for faculty.¹ In its long history, the Academy has been a catalyst for the formation of medical libraries and archives as well as serving continuing medical

education interests through seminars and other worthwhile activities. In the 1960s, through an agreement with the Medical Society of New Jersey, the Academy became the designated teaching arm of the State Society. This unique relationship continues today, and its success is reflected in the sharing of office space in Lawrenceville since 1979. On August 7, 1972, the Academy was approved as a category 1—sponsoring organization for a period of four years. At the same time, MSNJ instituted a mandatory requirement of 150 hours of approved study every three years for continuing membership.²

The Academy has 3,000 fellows who have an opportunity to choose a scientific section representing their specialty. This provides a professional forum for the exchange of ideas and accomplishments. Approximately 1,000 AMNJ members share their professional knowledge with others through voluntary participation in the Academy's prestigious Speaker's Bureau, the key ingredient for AMNJ's successful educational programming.

With scientific knowledge doubling every five years, the need for continuing education and professional development has become a routine element

r. Alessi is director of medical education, Dr. Davidson associate director for continuing medical education, and r. Heitzmann is executive director, Academy of Medicine of New Jersey. Requests for reprints may be addressed to Dr. Davidson, AMNJ, Two Princess Road, Lawrenceville, NJ 08648.

Table 1. Specialty sections of the Academy of Medicine of New Jersey.

Allergy	Obstetrics and gynecology
Anesthesiology	Oncology
Basic medical sciences	Ophthalmology
Bioengineering	Orthopedics
Clinical pathology	Otolaryngology
Dentistry	Pediatrics
Dermatology	Physical medicine and rehabilitation
Emergency medicine	Plastic and reconstructive surgery
Endocrinology	Preventive medicine and public health
Family practice	Psychiatry
Head and neck oncology	Radiation oncology
Hematology	Radiology
Infectious disease	Surgery
Internal medicine	Thoracic and cardiovascular surgery
Nephrology	Urology
Neurology	
Neurosurgery	
Nuclear medicine	

in each physician's professional life. The goal of the Academy's continuing medical education program is to provide a conduit where practicing physicians from urban and rural settings in New Jersey can advance their knowledge and improve their practice skills by selecting CME activities from the broadest spectrum of major symposia, one-hour roving symposia, specialty oriented meetings, courses, and self-directed learning programs.

All AMNJ educational programs are reviewed and approved by the Committee on Education. This Committee consists of nine fellows appointed by the Board of Trustees for a term of three years—three fellows retiring and three fellows appointed annually. Review of programs is supplemented by 64 physicians serving as scientific section officers.

The roving symposia series originated in the 1960s and continues today as a major thrust of the Academy. All New Jersey hospitals and medically related organizations have an opportunity to select one-hour symposia from a list of topics sent to them by our Committee on Education. Arrangements for speakers, publicity, and administration is provided by the Academy. Over 200 of these programs are held each year.

The Academy's Committee on Education annually selects approximately six to ten significant subjects of current medical interest along with program

chairpeople who are prominent in their field to develop large-scale, one-day programs covering various aspects on a given subject. The Academy is both active and proactive to the needs of its fellows and encourages recommendations for state-of-the-art programs. Two annual courses that have gained popularity are the "Intensive Review of Internal Medicine" and "The General Surgery Review Course." The courses prepare physicians for qualifying and recertification examinations and provide a comprehensive review of contemporary concepts.

AMNJ supports professional development of physicians by furnishing management services for most of the New Jersey medical specialty societies. The Academy provides administrative and secretarial support, financial management, legislative liaison, and medical/legal assistance through a centralized headquarters service. These societies sponsor over 250 hours of CME each year. The programs are screened by staff who offer consultation to the physician planning the activity on categorical essentials. Once reviewed and found to be acceptable, applications are forwarded to the Committee on Education for review. In all, these societies represent over 8,500 members.

The Academy will sponsor directly and will jointly sponsor with other organizations approximately

Table 2. Affiliated societies of the Academy of Medicine of New Jersey.

American College of Emergency Physicians, New Jersey Chapter	New Jersey Medical Directors Association
American Trauma Society, New Jersey Division	New Jersey Medical Women's Association
Association for Hospital Medical Education of New Jersey	New Jersey Obstetrical and Gynecological Society
Dermatological Society of New Jersey	New Jersey Orthopedic Society
Eastern Vascular Society	New Jersey Physicians Golf Association
Family Health Foundation of New Jersey	New Jersey Psychoanalytic Society
Medical History Society of New Jersey	New Jersey Society for Gastrointestinal Endoscopy
Middle Atlantic Society of Anesthesiologists	New Jersey Society of Colon and Rectal Surgeons
Nephrology Society of New Jersey	New Jersey Society of Critical Care Medicine
Neurological Association of New Jersey	New Jersey Society of Pathologists
New Jersey Academy of Family Physicians	New Jersey Society of Physical Medicine and Rehabilitation
NJ Assoc. of Electromyography & Electrodiagnosis	New Jersey Society of Plastic and Reconstructive Surgeons
New Jersey Association of Medical Specialty Societies	New Jersey State Society of Anesthesiologists
New Jersey Committee for Quality Orthopedic Care	Oncology Society of New Jersey
New Jersey Gastroenterological Society	Radiological Society of New Jersey
New Jersey Health Sciences Group	Urology Society of New Jersey
New Jersey Institute of Ultrasound in Medicine	Vascular Society of New Jersey

000 meetings during any given year. Over 90,000 participants will attend these meetings annually. MNJ, in conjunction with MSNJ, coordinates a statewide calendar of events that has as its primary purpose the avoidance of conflicts and optimal use of our available teaching talent. Each sponsor of a CME activity is asked to clear a date for a proposed event and when the date is firm, register the program with the education program coordinator. This process frequently brings together organizations as cosponsors of one event that might have otherwise been fragmented. In addition, the Academy publishes an *Annual Calendar* of events each summer that includes approximately 500 forthcoming activities for the upcoming academic year. The *Monthly Program* issues also are disseminated each year to assure total inclusion of current listings; these issues allow for date and program changes, deletions, and additions that update and supplement the *Annual Calendar*.

All of the listed programs are certified by the Academy's Committee on Education to meet the criteria for credit in category 1. The Academy requires a program chairperson, who is responsible for the submission of the application. The program provides the guidelines for program planning that lead to category 1 program approval. Included in the application are the ACCME Accreditation Essentials that specify need, program objectives, faculty, educational methods, and program evaluations for each category 1 program.

The program need is a statement of why this particular CME effort was undertaken. Often, it is required to aid physicians in better patient care. Program objectives clearly define what the participant is expected to learn from this endeavor and how this experience will impact on knowledge, attitudes, or

behavior. Sound educational objectives form the basis against which one can evaluate the program. Faculty must be listed with their titles, credentials, and affiliations. Educational methods explain how the instructional activity will be implemented. Finally, the evaluation will indicate how well the goals and objectives were achieved. Emphasis is placed upon the knowledge, instructional delivery, and preparation by the faculty.

The program chairperson also must assume responsibility for the program evaluation and return of the master attendance sheet of participants at every meeting. The Academy provides a certificate of attendance to all attendees for each sponsored and jointly sponsored meeting. All documentation of AMNJ-approved category 1 programs and participants are kept in permanent course files for a period of no less than six years.

Accreditation of institutions and organizations in New Jersey which sponsor continuing medical education is the responsibility of the Medical Society of New Jersey through its Committee on Medical Education. The criteria and standards for accreditation have been established by the national Accreditation Council for Continuing Medical Education (ACCME). ACCME recognizes the authority of state medical associations to accredit intra-state institutions and organizations.³ The Academy received a full six-year approval from ACCME to grant category 1 credits in December 1985. This is the maximum period available and reflects the excellence of Academy programs as determined by the national accrediting body.

A complete range of CME programs and consultative services are available to specific institutions and relevant government bodies or divisions. In 1987, the New Jersey Division of Developmental Disabilities

of the New Jersey Department of Human Services coordinated efforts with AMNJ to develop and implement a statewide system of continuing medical education. In less than one year, all ten facilities had an ongoing series of approved continuing education programs selected and designed to meet the special needs of professionals serving clients with developmental disabilities.

The Academy has responded to requests for proposals in highly specific areas. Funding from the New Jersey Department of Health (NJDOH) and private foundations has been forthcoming to develop curricula for Alzheimer's disease; environmental lung disease; physician education for prevention of diabetes-related lower extremity amputation, retinopathy, nephropathy; diabetes, and pregnancy; and AIDS. Valued members of the Academy who are experts and readily available in these areas work with their colleagues to design curricula and faculty development programs for the designated topics. In most cases, slides, a monograph, and outline are available to faculty to assure consistency and continuity for all of the lectures.

A statewide assessment in a conjoint effort with the Medical Society of New Jersey and the New Jersey Department of Health, Division of AIDS Prevention and Control was conducted to discern physician's AIDS testing referral procedures and AIDS testing pre- and post-test counseling practices. This survey of 10,000 physicians assessed the extent to which HIV counseling and testing exists in private practice in the state. It also solicited information concerning the extent to which state-funded HIV counseling and testing sites (CTS) were being utilized for referrals, and the perceived need for continuing medical education related to AIDS. The final report will serve as a needs assessment and valuable tool for AIDS education program planners. The implications for providers of continuing medical education are noteworthy.

The Academy is funded by NJDOH for an AIDSLINE, which provides central coordination for a statewide resource referral hotline accessible to all health care providers and community service organizations with information about AIDS-related education programs. An AIDS education program manager is available on a daily basis and can be reached by calling 1/609/896-0486. AMNJ will work closely with all sponsoring and requesting institutions as well as the NJDOH Division of AIDS Prevention and Control to disseminate a flow of infor-

mation on AIDS education and educational materials.

AIDSLINE publishes a monthly newsletter announcing AIDS educational programs in New Jersey and nationwide. Additional items are included in the newsletters such as availability of clinical trials, constant reinforcement of information on New Jersey testing and counseling sites, and availability of new services. AIDSLINE acts as a clearinghouse for CME coordinators, gathers sought after information for physicians and health professionals on AIDS and AIDS-related subjects, and collects data that often are considered to be means of identifying specific areas for future program planning.

The Academy has entered into an agreement with PICME (Physician Initiated CME). This is a project of a consortium of seven medical schools (SUNY-Stonybrook, Temple, McMaster, Georgetown, Minnesota, Albany, and Wisconsin) under the auspices of the Society of Medical College Directors of CME. The purpose of this new affiliation is to offer members of the Academy a new and innovative means of gaining AMA/PRA category 1 CME credit through individualized learning contracts. The physicians can define their own learning needs and the skills they wish to acquire. By using PICME Guidelines for Development of Independent Contracts, the Academy coordinates and administers the CME projects. At this time, several Academy members have entered into learning contracts with their peers.

CONCLUSION

The main goals for continuing medical education are to help physicians review fundamental concepts and keep abreast of the current state of the field (traditional CME) and to help physicians improve their care of individual patients (practice-linked CME).⁴ As the only organization in New Jersey totally committed to the continuing education interests of private practitioners, the Academy is dedicated to the perpetuation of the spirit of volunteerism in the sharing of information among physicians. New initiatives always are under consideration and present practices constantly are re-evaluated. Continuing medical education is a dynamic and ever-changing process. The Academy looks for involvement in new technologies, creative modes of instructional delivery, and developing and administering focused/prescribed/remedial education to enhance clinical competence. ■

REFERENCES

1. Personal notes, Arthur Bernstein, MD.
2. Saffron MS: *A History of the Academy of Medicine of New Jersey*. NJ, Academy of Medicine of New Jersey, 1981.
3. *MSNJ CME Procedural Manual*.
4. Manning PR: The future of continuing medical education, in Rosof AB, Felch WC, *Continuing Medical Education: A Primer*. New York, NY, Praeger, 1986

The Role of AMNJ

*al Heitzmann has been executive director of the Academy of Medicine of New Jersey since 1973. Guest
ditor Alan J. Lippman, MD, interviewed Mr. Heitzmann concerning his role at AMNJ.*

Q: What are your responsibilities as executive director in promoting CME in New Jersey?

A: As you know, the Academy was formed in 1911 with the express mission of sponsoring high-quality, continuing medical education for New Jersey physicians. Upon joining the Academy staff in 1973 as executive director, I have made every effort to continue that mission.

If you recall, the early 1970s was a critical time for medical education. The AMA's Physician's Recognition Award (PRA) was becoming a factor and the Medical Society of New Jersey instituted mandatory CME requirements for members. The MSNJ program which utilizes the AMA PRA criteria of 150 hours every three years continues today as a successful effort. In addition, the Academy was approved by the AMA as an institution accredited for CME in 1972.

With all of these factors in place, it was necessary for the Academy to expand its programming of direct CME activities, as well as offer other health care institutions in New Jersey the ability to jointly sponsor CME offerings with the Academy. It was necessary to institute a system of committee review involving physicians from every specialty to assure that these activities met the high ideals set by the Academy for its own directly sponsored category I courses. This system of jointly sponsored programs enabled us to meet the needs of New Jersey physicians and continues today as a model for the coun-

The decades of the 1970s and 1980s witnessed an expansion not only of our programs, but the development of our publications which have the primary purpose of publicizing and promoting our activities. The Academy's *Monthly Program* has become a popular and essential document in New Jersey medicine. It has a monthly circulation of 3,000. Our major publication, the *AMNJ Annual Calendar*, is

published each August as an introduction to the academic year.

Every effort is made to keep abreast of the latest developments in CME technology. Although I personally believe the old lecture format always will be a part of the continuing education of physicians, the Academy's education staff has been aggressively pursuing new formats. Computer-based education, home study courses, satellite network programming, and audio-video tapes are some of the new technologies.

Q: What is the relationship of AMNJ and MSNJ?

A: I frequently am asked to explain the relationship, and the difference, between the Academy of Medicine and the Medical Society. Obviously, we are two separate and distinct organizations that share executive office space in Lawrenceville and provide membership services to the medical profession. The Academy is a nonprofit 501(C)3 tax-exempt organization which has as its primary objective the sponsorship of continuing medical education programs. The Medical Society is a nonprofit 501(C)6 tax-exempt organization which acts as the trade/professional association for New Jersey physicians.

In the mid-1960s, the Medical Society appointed the Academy of Medicine as its designated teaching arm. This relationship has been productive for both groups and becomes stronger as years pass. There is no other state that has two distinct organizations working so closely, cooperatively, and successfully on behalf of the medical profession.

As you know, the Academy provides most of the state's specialty societies with office management services. We initiated this service in 1973 soon after I became executive director, and currently we assist 33 organizations with administrative, secretarial,

and financial needs. The marriage of these groups under one roof has proven extremely productive for all of medicine. We have attained permanence and continuity. We have achieved significant efficiency in our efforts to reduce cost through the utilization and sharing of staff, equipment, supplies, and space.

Q: How did you get involved in AMNJ? How has AMNJ matured under your guidance?

A: Prior to joining the Academy staff in May 1973, I was employed for four years by the New Jersey Regional Medical Program as associate coordinator for heart disease programs. In that capacity, I had the opportunity to meet and work with many influential New Jersey physicians who also were actively involved with the Academy.

The early 1970s was a critical time when the Academy's Board was resolving questions on the organization's future; one of which was to hire its first full-time executive director. I was hired by Dr. Leo Siegel, president of the Academy (1972-1973). However, Dr. Arthur Bernstein, who was on the Board of the Regional Medical Program and an officer of the Academy, and Dr. Jim Rogers, a colleague at the Regional Medical Program and an AMNJ Board member, both played pivotal roles in my coming to the Academy.

In May 1973, the Academy was located in Bloomfield, had three employees, and was involved with 20 to 25 CME programs per month. The Academy sold its property in Bloomfield and relocated to Union until the decision was made to permanently relocate to Lawrenceville with the Medical Society of New Jersey in 1979. The decision was made for various reasons, including the need to become better centrally located within the state. Our need for additional office space, the opportunity to utilize the various meeting rooms on the premises, and the increasing necessity to interact with the State Society on a daily basis helped firm our decision.

As we approach the decade of the 1990s, I am pleased that the Academy now is a well-recognized and respected professional society representing over 2,600 physicians and every specialty of medicine. We currently employ 16 staff members who are dedicated to their work and enjoy working with the medical profession. As we look to the 1990s, we are proud of what we have accomplished and look forward to continuing our success into the future.

Q: How do you feel AMNJ has performed in maintaining adequate CME?

A: The Academy responded in 1973 to the need to offer a significant increase in CME due to the new MSNJ membership requirement as well as other specialty society requirements. While we were in-

creasing our numbers, we also were looking at physicians' needs and trying to assess those needs. Today, needs assessment is an essential part of the planning process for any organization that sponsors CME programs. I feel almost all New Jersey physicians should be able to find CME offerings of interest to them on a monthly basis in our *Monty Program* and various mailings.

In my opinion, the most difficult job of the CME professional is to evaluate the impact of a given educational endeavor on an improvement in medical care. I believe the quality of medical care does improve with CME, but at this time no one has been able to conclusively prove this.

Q: How is the Academy changing or developing to meet the needs of physicians in the 1990s?

A: The Academy has been meeting the needs of New Jersey physicians for 78 years by offering a wide assortment of programs and activities. Scientific section meetings, roving symposia held in the hospital setting, all-day major symposia examining a subject in depth, and efforts with our county and state medical societies are examples of past and present symposia that will continue into the future.

With the increased demand on physicians' time and our ever-present search for leisure activities, the Academy is seeking new ways to include CME in a viable form to fit an individual's active schedule. We currently are looking at innovative means of providing computer-assisted instruction (CAI). The computer provides dynamic interaction between the student and the instructional programs. The obvious benefits are immediate feedback, opportunity to learn through initial mistakes as indicated by objective appraisal and, of course, ease and convenience of scheduling. Artificial intelligence (AI) is a natural progression and the next step after CAI. AI increases one's capacity for accurate decision making and expands instructional dialogue in ever-increasing areas.

The Academy has assisted several New Jersey state departments and divisions in implementing systems-wide journal clubs with the purpose of increasing physician awareness of new developments. These forms of individualized learning also are applicable to our recent entry into PICME (Physician Initiated CME). This form of individualized contractual learning allows the physician the ability to select specific areas of medical information he or she needs, as well as choosing experts who are qualified to assist him in the acquisition of new knowledge.

In essence, the Academy continues to make every effort to be on top of new developments and provide our members with the latest in CME innovations. New ideas always are welcome and we encourage members to contact our office at any time. ■

Hospital Medical Education

STEPHEN F. WANG, MD
RONNIE DAVIDSON, EdD

The Association for Hospital Medical Education of New Jersey (AHME-NJ) was organized to assist in developing, providing, and maintaining sound graduate and continuing education programs in the state of New Jersey. It is an affiliate member of the national Association for Hospital Medical Education (AHME). The objectives are to provide a forum for those interested in medical education at the house officer (graduate medical education) and attending physician (continuing medical education) levels, to act as liaison to cooperate with all agencies, organizations, and institutions directed toward all phases of medical education, and to provide a vehicle of research in medical education and patient care in New Jersey. Mem-

bership consists of physicians and other educators from New Jersey hospitals and universities who have demonstrated an active interest in medical education.

Wang is director of medical education and research at Morristown Memorial Hospital, former president of AHME-New Jersey, and president-elect of AHME. Dr. Davidson is associate director for continuing medical education, Academy of Medicine of New Jersey. Requests for reprints may be addressed to Dr. Davidson, AMNJ, 100 Princess Road, Lawrenceville, NJ 08648.

The leadership of this organization has directed its efforts to the furthering of intrahospital staff education, and in continuing medical education (CME), in teaching and nonteaching hospitals. It also has assisted hospitals with advice and guidance in the areas of audit and utilization. Throughout AHME's history, an emphasis has been on the upgrading of surveying skills and instruction of CME hospital surveyors, organizing mini-residencies, and publicizing their availability throughout the state.

Over the past ten years, AHME-NJ has promoted CME in the state through sponsorship of numerous educational programs and symposia. In 1979, a program entitled, "Medical Staff Officers—Their Goals and Roles," was presented, followed in 1980 by "The Physician and the Hospital: Their Shared Responsibility." "How Physicians Learn: Effective Methods in CME" was the 1981 program. The following year,

AHME examined "Prescription Drug Abuse, Misuse, and Diversion."

In 1985, a full day was devoted to a workshop for medical educators. This workshop was designed to meet needs articulated by the MSNJ Committee on Education for directors of medical education, hospital medical directors, quality assurance personnel, and hospital staff involved in CME management. This workshop focused on assisting directors of medical education, residency program directors, medical education coordinators, and staff to identify practical evaluation methods to apply to their programs and to recognize the value of practical evaluation. Discussions focused on hospital medical education issues with representatives from AHME-National, AAMC, and the Advisory Graduate Medical Education Council of the New Jersey Department of Higher Education.

During that same year, another workshop was held and the application of quality assurance findings in medical education at graduate, under-

graduate, and postgraduate levels were reviewed; successful endeavors in this area were addressed. The inherent difficulties of linking quality assurance and medical education were discussed as well as the role of medical education in the quality assurance process.

"Continuing Medical Ethics: Designing Successful Programs" was the theme of a workshop developed to fulfill the need of practicing physicians and house officers to expand their understanding of basic ethical dilemmas, the knowledge, skills, and attitudes necessary for dealing with them, and the most effective pedagogical options for training physicians in medical ethics. The stated objectives of this program were to identify the most important purposes of bioethics teaching, in terms of knowledge, skills, and attitudes. The major obstacles facing CME programs in bioethics were analyzed and the most effective means of instructional delivery for the aforementioned programs were discussed.

Other symposia dealing with accreditation issues have been held. One innovative symposium was designed to meet both the needs of the persons who are members of the team and those who are the recipients of the survey; in this workshop, attendees participated in both aspects of the issue—surveyors and surveyees. New changes and trends in national accreditation standards for CME were viewed, as well as an update of how they impact statewide accreditation procedures and reporting mechanisms. Emphasis was given to CME accreditation standards and requirements for community hospitals.

A recent symposium, sponsored by AHME, was entitled "New Dimensions in Medical Education" and was conducted in December 1988. Information was provided on the state-of-the-art computer applications in graduate and continuing medical education. Participants were apprised of self-directed practice-related CME opportunities. Practical applications for the computerization of medical education offices were introduced.

Since 1973, AHME-NJ has been provided with administrative services by the Academy of Medicine of New Jersey. This has fostered excellent working relationships with groups dedicated to medical education, including the Medical Society of New Jersey and the Academy of Medicine of New Jersey and their respective education committees.

AHME-NJ represents all of those physicians involved in hospital medical education, within the state (representation in the Advisory Graduate Medical Education Council-AGMEC of New Jersey) and at a national level (Association for Hospital Medical Education). Many AHME-NJ members have held leadership positions in the national organization. ■



Robert Wood Johnson University Hospital.
© Cliff Moore.

NJHA and Continuing Education

LOUIS P. SCIBETTA

Founded in 1918, the New Jersey Hospital Association (NJHA) has, as its mission, the advocacy for health care services provided by New Jersey hospitals, nursing homes, and other health care institutions. Through its current membership of 126 institutions, the Association seeks to provide guidance in shaping policy and improving the organization and delivery of quality health care.

Along with other affiliated organizations, based at its Center for Health Affairs in Princeton, NJHA offers a variety of services. For example, NJHA: represents member institutions on legislative and regulatory problems before the Health Care Administration Board, Hospital Rate-Setting Commission, and other regulatory and legislative bodies; assists member hospitals in assessing and providing solutions to manpower needs; communicates common problems and accomplishments among member institutions through several publications and other media; and joins with MSNJ in conducting continuing medical education programs for physicians and hospital administrators, jointly working to develop position papers on health care issues.

The following article presents an opinion piece by the president of NJHA, in which he addresses a current major concern of his organization, that is, how quality CME can be maintained given the severe economic constraints imposed by today's health care economy.

The far-reaching and complex decisions that center around graduate medical education—who receives it, how it is delivered, where it is delivered, to what extent it is evaluated, and what impact it has on access to care—should not be driven by economics. Having said that, I need not remind you that hospitals and physicians are partners in an ever-tightening regulatory arena that demands otherwise.

Mr. Scibetta is president of the New Jersey Hospital Association. Requests for reprints may be addressed to Mr. Scibetta, NJHA, 760 Alexander Road, CN-1, Princeton, NJ 08543-0001.

Continually concerned with prospective cost containment and retrospective peer review, physicians and the hospital management team find themselves as allies on a daily firing line of bottom-line accountability. Part of that accountability, particularly in New Jersey, demands that we do more with less.

Graduate medical education (GME) is no exception. Until someone comes up with a workable alternative to adequately support residency training, funding for graduate medical education continues to be derived from the patient care dollar, even as that dollar shrinks. Therein lies the challenge.

Reagan-proposed, Bush-endorsed federal deficit reduction plans call for \$5 billion in Medicare cuts nationally for the fiscal year 1990 budget. This meat-cleaver approach to budget management would translate into a \$106 million Medicare shortfall for New Jersey, \$35 million of which would impact graduate medical education, both direct and indirect costs.

Also, there is no doubt that the state's reimbursement system will experience a traumatic diminution of funding from continued cutbacks on the federal level.

In wake of such continuing constraints, NJHA agrees with the American Hospital Association (AHA) recommendations made before the Council on Graduate Medical Education, namely: society

has an obligation to adequately fund residency training; as any other payor, Medicare should contribute its proportionate share to the costs of graduate medical education; Medicare payment policies should not produce disruptive or radical shifts in the distribution of hospital revenues; arbitrary limits on funding must be avoided.

STATE INITIATIVES

Initiatives by the New Jersey State Department of Health (NJDOH) to accommodate reimbursement reform reflect a course originally charted by NJHA more than two years ago under the banner "Objective for Change." However, as part of the proposal, NJHA endorses a cautious approach to change. Many of the state's proposals relative



Robert Wood Johnson University Hospital.
© Cliff Moore.

graduate medical education are not yet sufficiently understood.

NJDOH has proposed to eliminate teaching peer groups and suggests a continuous teaching adjustment. This new methodology would be more reflective of the types and numbers of residency programs that exist in the state as opposed to the number of residents trained.

Although there are pros and cons to this approach, confusion over regulatory language and serious reservations about resulting impact seems to make discretion the watchword for now.

It is obvious that more work needs to be done by the state in explaining and modeling, before new reimbursement standards are set in stone. For example, the state initially proposed that no accommodation be made to compensate for the training of family practice physicians. Not fully funding such an integral component of the health care delivery team would be wrong, and may lead to an exacerbation of shortages of these physicians.

In short, we should accept nothing less than adequate and equitable reimbursement levels for GME that reflect institutional reality and the community's demand on the health care delivery system.

The mutual goal of clinicians, educators, and administrators should be to fully develop hospitals as the ideal venue for providing the best possible combination of didactics and experience. This takes planning, foresight, and funding.

If, however, reimbursement dollars continue to change significantly and disproportionately, regulators must be forewarned: We very well may see a time when the number of institutions providing GME in this state changes also. But if that becomes the case, funding to these hospitals must be made another category to allow them to hire fulltime physicians to staff services that patients may not otherwise have available to them.

Under this scenario, medical education will suffer. The medical and hospital communities should not tolerate this. New Jersey should be able to stand at the same level as any other well-financed state with very high economic standards.

FOREIGN GRADUATES

The issue of the use of foreign medical graduates (FMGs) in New Jersey hospitals is a double-edged sword. On one hand, the proliferation of foreign medical graduates no longer should be deemed an acceptable standard for ensuring adequate medical manpower in our hospitals. In fact, the state's hospitals' dependence on foreign graduates has dropped from a nation-leading 58.6 percent of total hospital residents in 1985 to a current FMG percentage of approximately 45 percent.

On the other hand, we also must recognize that

many inner-city hospitals which provide the bulk of health services to their communities are heavily dependent on FMGs to provide that care.

The reimbursement system needs to concern itself with those institutions, particularly in urban areas, which utilize FMGs to provide health care services to patients who otherwise would not get those services.

It should be noted that until the creation of the University of Medicine and Dentistry of New Jersey (UMDNJ) nearly 20 years ago, New Jersey did not have a state-supported system of medical education.

Until such time as reality caught up with perception, the state's GME programs historically have been considered to lack sufficient educational excellence to attract United States medical graduates (USMGs).

This couldn't be further from fact today. With the UMDNJ system as the fulcrum of the state's diverse and rich mix of residency programs, more than 40 hospitals currently hold major or minor teaching status with UMDNJ, as well as with other prestigious medical schools in Philadelphia and New York.

Increased status and demonstrated results go hand-in-hand. The actual quality and caliber of the state's GME programs have experienced gradual and encouraging progress in terms of perception and enrollment by USMGs.

The number of USMGs steadily has increased since the inception of UMDNJ and the establishment of the graduate medical education program under the aegis of the New Jersey State Department of Higher Education.

But the pendulum that swings away from foreign medical graduate dependence moves slowly, as it should. Too drastic a change in public policy on this issue might negatively impact the needed and vital services provided by these teaching hospitals.

Access to care and training of medical professionals should not become jeopardized as a bargaining chip in a fast-paced game of public policy or budget deficit roulette. In order to ensure the stability of New Jersey's teaching hospitals and the integrity of the GME system, abrupt changes to the system may hurt more than they help. In the interim, we must collectively demand full funding for graduate medical education, while all physicians oversee and assure excellence in the quality of that education.

Hospitals historically have been not only the physician's primary work place, but also their training place. It is time for the medical community, along with the hospital industry, to make it clear to those who regulate us and determine our reimbursement levels that we mean to protect that environment from further erosion. ■

Your own medicine.



The Exchange is the *only* company providing professional liability insurance that is endorsed and sponsored by the Medical Society of New Jersey.

The Exchange was founded in 1976 by the Society itself because New Jersey physicians urgently needed a secure, stable professional liability program. The commercial carriers had abandoned the State. The Exchange is governed by its insured physicians because a doctor-owned company can best take care of medical professionals' needs.

That's why the Exchange's membership includes more than 7,500 practicing physicians and surgeons in New Jersey... a taste of their own medicine.



**Medical Inter-Insurance
Exchange of New Jersey**

2 PRINCESS ROAD, LAWRENCEVILLE, NEW JERSEY 08648
800-257-6288 609-896-2404

The Academic Health Center in CME

ROBERT R. MOUTRIE, PhD
WILLIAM S. VAUN, MD

As medical information continues to grow at a rapid rate, academic health centers (AHC) must react to the needs of physicians by developing new roles in the provision of continuing medical education (CME). These roles utilize new methodologies for providing relevant and manageable information to practicing physicians. The University of Medicine and Dentistry of New Jersey (UMDNJ) is extensively involved as a primary provider of traditional continuing education opportunities, and will continue in this role, yet new methods of outreach are on the horizon, including: a network of continuing medical education affiliates, the development of concentrated mini-residencies, and the utilization of a telecommunications system to provide a continuing and timely interface between the University and the practicing community. UMDNJ-Office of Continuing Education (OCE) has begun to develop a network of continuing education affiliates. This relationship goes beyond simply providing speakers and now includes OCE staff who work with those responsible for CME within the participating hospital. Together, UMDNJ and the hospital develop a needs assessment, using quality

assurance materials, questionnaires, and interviews with selected members of the medical staff. OCE staff assist in developing relevant programs, scheduling speakers, and incorporating an evaluation process to assess the impact of the program and identify future needs. This is a time-consuming process, but does produce a program of greater continuity and relevance, and has begun to establish free and ongoing channels of communication between the academic health centers and the community hospital. Initial successes have proved rewarding both for the hospitals involved and for UMDNJ. In addition, in cooperation with a professional specialty society, similar programs are in the early stages of implementation.

Those involved in CME are aware that reading and structured conferences are the mainstays for sustaining competence in a continuing fashion; yet, individual deficiencies may not be addressed adequately through these modalities. While some individuals may continue to be unaware of their deficiencies, quality assurance programs are bringing more of such situations to light than ever before. UMDNJ hospitals have addressed such problems as they arise by meeting individual needs of selected physicians with tailor-made mini-residencies.

As effective as mini-residencies have been, there are several potential problems with expanding such programs. At a recent meeting of the Alliance for Continuing Medical Education, participants ad-

Dr. R. Moutrie and Dr. Vaun are affiliated with UMDNJ, Office of Continuing Education. Requests for reprints may be addressed to Dr. Vaun, UMDNJ, Administration Complex, 30 Bergen Street, Room 1208, Newark, NJ 07102-3007.



dressed the complex issues in "remedial" medical education, starting with the title. As "remedial" might appear pejorative to some and prove embarrassing to participants, alternative names were debated, not to disguise the effort, but to make it more acceptable and a more integral part of the continuum of medical education. Another issue is that the term mini-residencies, might imply to some that these are simply programs grafted onto existing residency programs. This, of course, is not the case. Each program is a uniquely tailored experience for the individual physician and not just a rotation through a traditional residency program. Finally, several legal issues were identified which must be resolved to facilitate these educational opportunities. In spite of all these concerns, there was a consensus that there is a growing need for such programs. UMDNJ is in a position to assist certifying agencies, the Medical Society of New Jersey, professional specialty groups, hospitals, and individual physicians as needed to develop programs in this important arena.

Some of the most exciting possibilities for CME involve utilization of new technologies. UMDNJ currently is exploring one such approach which involves a state-of-the-art telecommunications network. Modifying the systems developed in other AHCs, UMDNJ is planning an 800 exchange in the new network. This will be for the exclusive use of practicing physicians to contact UMDNJ faculty and services. Direct physician-to-physician contacts will be provided for timely consultations and discussion of specific questions or problems. Access to University health services or facilities also will be provided. Resolving problems or questions at the moment they arise has significant potential impact on the quality

of care and the effectiveness of the learning experience. In repeated studies, patient consultations are second to reading as the most effective source of CME. We hope to build on this approach and use new technologies to provide expanded opportunities for such consultations.

Another technological approach involves computers. The computer currently being used for business purposes in many medical offices also can serve an important CME function. Though this is not included initially as a part of the telecommunications network, it may evolve as an active component. There currently are several programs a physician may access through an office personal computer. These include bibliographic searches and sources of focused medical information. There also are computer interactive learning programs available which may be too costly for an individual purchase, but are excellent learning tools and may be provided through hospital libraries or other sources. UMDNJ plans to introduce services which will increase physician awareness of materials currently available and provide opportunities to build the basic computer skills needed to participate in these programs.

CONCLUSION

UMDNJ is working to become a more efficient and effective provider of traditional continuing education opportunities while it explores new roles of the AHC in continuing medical education. To accomplish this, the University of Medicine and Dentistry of New Jersey will be seeking opportunities to work with a broad spectrum of constituencies, including individual physicians, professional organizations, and health care agencies. ■

Down-to-Earth Medical Education

RICHARD K. GOODSTEIN, MD

A fourth-year student watches a program describing the anatomy of the brain on a television receiver on the fifth floor of a medical school building. On the floor below, a resident arches his monthly program guide for the next scheduled time for a lecture by a visiting professor recorded months earlier. Unable to wait for that recast, he calls the television control center and requests the program, and it is played immediately. Elsewhere, trainees and nurses gather in seminar groups to view and discuss programs on other channels, while community private practice physicians and attending faculty at the adjacent hospital view channel dedicated to continuing medical education (CME).¹

Satellite television represents a significant alternative for medical education.² By using a live satellite television medium, teleconferences can bring experts with the most current information directly to hospitals and to private practice facilities equipped with a downlink (receiving dish). Because many teleconferences are interactive, such questions being asked by individual viewers from distant downlink sites, the learning environment is not passive. Teleconference participants

react with interest to immediate contact with the television consultant faculty and to the inherent drama of the live setting. Category 1 (CAT) and American Academy of Family Practice (AAFP) CME credits are available for the live interactive shows and also for videotaped shows which are accompanied by a syllabus and post-test.

MIND AND BODY

One such model for televised medical education is a live weekly series entitled, "Mind and Body," produced and broadcast nationally from studios in Princeton. Seven of the top private psychiatric facilities in the nation have joined with the Hospital Satellite Network (HSN), a Princeton and Los Angeles, California-based satellite television service, to produce "Mind and Body" as accredited medical educational programs offering "down-to-earth" advice on diagnosis, intervention, and treatment of interrelated medical and mental health issues. This weekly program series airs on Fridays 1:00-2:00 P.M. eastern standard time via the communications satellite called SPACENET I (on Transponder 6, channel 11) which is in orbit 25,000 miles above the earth (Table). "Mind and Body" covers a broad range of topics in the behavioral sciences including AIDS, Alzheimer's disease, anorexia nervosa, anxiety, alcohol/cocaine abuse, depression, suicide, and neurological disorders. The information is appropriate for community primary care physicians, staff members of general acute hospitals, and staff members

Goodstein is clinical professor of psychiatry, UMDNJ-Robert Wood Johnson Medical School and senior vice-president, Carrier Foundation, and creator/executive producer of "Mind and Body." Requests for reprints may be addressed to Dr. Goodstein, Carrier Foundation, Route 1, Belle Mead, NJ 08502.

of mental health centers and psychiatric hospitals. Programs are live, providing viewers the opportunity to ask questions via an 800-telephone line. Topics are scheduled in advance to allow staff to place the event on their calendars.

Psychiatric institutions contributing to the weekly program series include the Brattleboro Retreat, Vermont; the Carrier Foundation, New Jersey; the Cleveland Clinic Foundation, Ohio; Florida Hospital, Orlando; Philadelphia Psychiatric Center, Pennsylvania; Sheppard and Enoch Pratt Hospital, Maryland; and South Oaks Hospital, New York. The participating hospitals were invited to join the project because of their inhouse expertise in particular specialties, their ability to attract outside experts with national reputations, and their proved commitment to continuing education in the behavioral sciences.

Each program features three to five faculty members present in the studio, along with a discussion moderator. Such programs include learning objectives, practical consultative "how to" suggestions, and written (graphics) clinical points. Brief, pretaped action footage serves as an introductory roll-in. Actual live patient interviews also may take place. In addition, resources for obtaining supplementary information are given at the conclusion of each program.

Any health professional, including specialty physicians, psychologists, social workers, and pharmacists viewing these programs are eligible to receive CAT 1 continuing education units (CEUs) in their respective fields. In addition, viewing is recommended for nurses and any health care personnel involved in direct patient care.

HSN PROGRAMMING

HSN transmits daily a wide variety of other in-service, continuing medical education, and management information programs to over 1,000 hospitals

and many clinics, agencies, and office-based practices throughout the United States and Canada. Evaluation forms are available from HSN for each major program and viewer surveys seek subscriber content interest, needs, and suggestions.

These shows may be simultaneously videotaped by subscribers for reshowing to off-duty staff and staff and/or trainees at more conveniently scheduled education seminars in each facility. Many of the live and/or taped shows are very suitable for patient family education as well as for positive public relations material for interested community service clubs, schools, and individuals.³ The tapes may be placed in the hospital medical library with appropriate accompanying literature to be loaned to staff for home use and CME credit in the same manner as a book, or for programmed study in the library.

SUBSCRIBING TO THE SERVICE

Subscriber service to HSN can be established quickly for any private practice office, agency, clinic, hospital, nursing home, industry, or college which has health care education as an interest for its staff. Service available is based on the number of hours of programming in packages from 2 to 24, requested on a Monday through Saturday schedule. The program content of those hours involves choosing a portfolio module, or a specific focus/track from such areas as medicine, nursing, and patient education.

Pricing depends on several variables such as the number of hours per day chosen, the size of the subscribing facility, and whether the subscriber is individually requesting service, or a larger consortium of similar facilities is interested in signing up as a group package.

Although many hospitals, companies, and schools already have the technology of a downlink dish antenna wiring in place, there is a one-time purchase of equipment necessary if the facility is not yet outfitted. The requirements to bring in the television

Table. Mind and Body schedule, fall 1989. Shows are Fridays, 1:00 to 2:00 P.M.

Date	Time	Host Hospital
September 29	Grief and its Sequelae	Florida Hospital
October 6	Uncovering Depression with Psychotic Features	Carrier Foundation
October 13	Following the Doctor's Orders	Sheppard-Pratt
November 3	Brain Waves of Today	South Oaks
November 10	Advances in Treating Schizophrenia	Sheppard-Pratt
November 17	The Sad Story of Diabetes/Arthritis/Cardiovascular Disease	Brattleboro Retreat

gnal involve: (1) a motorized satellite dish which can be installed on the ground or roof; (2) wiring from the dish; (3) "head-end" or black boxes, which receive and distribute the signal in the facility; (4) a decoder to unscramble the downlinked TV signal; (5) wires from the head-end; (6) television set; (7) a telephone with an outside line to interact with live programs; and (8) a videocassette recorder. This equipment can be purchased separately or from the HSN subscriber service as "one-stop shopping." Additional HSN subscriber and CME credit information is available by calling 1/800/638-3336.

OTHER MEDICAL TV SERVICES

Two other medical education television services currently are broadcasting on regular commercial cable television. These are available, however, only on a limited (one day per week) basis, are pre-recorded rather than live, and provide no interactive opportunities.

Lifetime Cable Network features taped shows on medical topics with CAT 1 CME under the title of "Physicians Journal Update," and telecasts in New Jersey each Sunday at 4:30 to 6:00 A.M. Call 718/482-4000 for more information.

American Medical (Association) Television (AMT) started broadcasting taped shows in January 1989 and will do so every Sunday from 10 A.M. to 12 noon eastern time on the Discovery Cable Channel. In fact, an edited tape version of "Mind and Body" will be a frequent 11:30 A.M. to 12 noon segment of AMT. A study guide and CME credit information may be obtained by calling 1/800/621-8335.

EXPANSION AND UTILIZATION

The satellite television process can be taken further in its natural course of expansion to provide an ultimate model of hospital or clinic-wide education integration. The Medical Education Department of Carrier Foundation has completed a four-phase program to install a closed-circuit television service for the hospital. The system is Carrier Cable System (CCS). Phase I was the installation of a satellite dish in 1984. The receiving dish enables Carrier to "downlink" HSN and all other decodable communication satellite television transmissions. Phase II of the process involved the installation of wiring throughout the main hospital to allow satellite and videotaped programs to be seen on televisions in the nursing units and at a total of 37 staff

locations throughout the main hospital building. Phase III of the process concentrated on upgrading the audiovisual wiring, sound, television, and projection systems in the amphitheater. The Atkinson amphitheater is the location in which weekly COMEDS (Grand Rounds), colloquia, and all-day symposia are held for the benefit of Carrier staff members and community professionals in the health field. These events are all televised live throughout the hospital to our employees with CAT 1 CME available. Phase IV included upgrading the distribution and quality of broadcasts, installing television cabling to outlying research and administrative buildings and a computerized motor to turn the satellite dish toward various broadcast locations in the sky. The TVRO (television receiving only) satellite dish allows the facility to receive broadcasts from several satellites—SPACENET I (location of HSN), SATCOM 3R, SATCOM 1R, WESTAR 3, and WESTAR 4. The system gives us the flexibility to make exciting, creative new education available for all disciplines as well as for patients and families.

CONCLUSION

Medical education brought directly to the physician over the television has distinct benefits. It is another source of CME in a whole range of options available today. Some specific advantages of satellite medical programming include videotaping convenience, interactive component, state-of-the-art content, practical clinical curriculum, and cost effectiveness compared to financing staff travel and time away for outside meetings.

Decisions whether to subscribe to such medical television services were more difficult in the "early years"—1984 and 1985—when a plethora of new television companies with no proved track record were in direct competition.⁴ Now, with only one satellite medical service and two regular once-a-week medical cable services, the management objections boil down to: relevance of program content; assignment of personnel (and related cost-time issues); and addressing the initially uncomfortable notion of having staff "watch television" while on the job.⁵

Educational opportunities via satellite and cable television are not futuristic visions of the medical education system of tomorrow. Rather, "the sky is the limit" for integrating practitioners, faculty, and trainees with technology available now for all health professionals in this style. ■

REFERENCES

1. Glazer H: Medical education and the new video technology. *International Television News*: 4, February, 1983.
2. Rasmussen TA: Video age. *Medical Meetings* 31-32: 84.
3. Brecher J: Keeping the patient in stitches. *Newsweek* 65: August 1, 1983.
4. Richards G: Television—year of decision on national network. *Hospitals* 73-81, 1982.
5. Crane P: Overcoming management objections to videoconferencing. *Telemarketing* 20-29, 1985.

When it comes to your patients' health leave no stone unturned.



Lithotripsy at

The New Jersey Kidney Stone Treatment Center can be the alternative.

Convenience—The New Jersey Kidney Stone Treatment Center is centrally located in downtown New Brunswick, near major highways, for easy access for you and your patients.

Flexible scheduling—The Center offers scheduling with no delay. In most cases, your patient can be treated within a week of your call. Our extended hours allow you to make appointments at the convenience of both you and your patients.

Bath-free equipment—The Center is equipped with the most advanced Dornier HM4 lithotripter, eliminating the need for a water bath, allowing for easier patient handling and greater patient comfort. Also in use is a state-of-the-art Shimadzu Hydrojust III cystoscopy table.

Experienced, professional staff—The staff of the New Jersey Kidney Stone Treatment Center is well-versed in lithotripsy treatment, and includes board-certified Anesthesiologists, critical-care trained nurses and skilled lithotripsy technicians.

Physician billing—Urologists treating patients at the Center have the advantage of billing their patients or third-party payers directly through their own offices.

Easy referral system—If desired, physicians can easily refer their patients to one of our staff Urologists for lithotripsy treatment.

HMO eligibility—The Center has established arrangements with most major area HMO's.

For more information regarding how the Center can help you and your kidney stone patients, call 1-800-542-8887 or (201) 937-8614.

New Jersey **Kidney Stone** Treatment Center

**Located at Robert Wood Johnson University Hospital
New Brunswick, New Jersey 1-800-542-8887**

The New Jersey Kidney Stone Treatment Center is operated by Health Horizons (ESWL), L.P., affiliated with the following hospitals: Community Memorial Hospital, Freehold Area Hospital, Helene Fuld Medical Center, Jersey Shore Medical Center, Raritan Bay Medical Center, Riverview Medical Center, Robert Wood Johnson University Hospital, St. Francis Medical Center, St. Peter's Medical Center, Somerset Medical Center.

The Computer Connection

STEVEN MARCUS, MD

Many physicians are learning of the important role of computers in modern medical life. Although the major use of computers, at this time, appears to be in the realm of office management, applications in continuing medical education (CME) rapidly are becoming more and more common.

Currently, 25 percent of all physicians in the United States have a personal computer in the office and, of these, many have two computers. As administrative demands on the practice of medicine increase, a greater proportion of physicians, no doubt, will enter the computer era.

Interest in computer-based CME has developed in recent years. The advantages of computer-based programs appear great. A physician can choose programs specific to his needs, use them at his leisure, and progress at his own personal rate. Continuing medical education then can be geared to a physician's practice-linked problems, tailor-fitting the subjects and the techniques.

Dr. Marcus is associate director of pediatrics, Newark Beth Israel Medical Center, and director, New Jersey Division Information and Education System, Newark. Requests for reprints may be addressed to Dr. Marcus, Newark Beth Israel Medical Center, 201 Lyons Avenue, Newark, NJ 07112.

Computer information databases (Table) are available which may be accessed through a modem at a physician's office and allow searching of the literature on given topics. With limited knowledge of the computer and minimal special training, the physician accurately can access these databases and obtain information on demand.

Examples of these databases are: the National Library of Medicine's (NLM) database, MEDLARS, Dialog, and BSR. These systems have become more "user friendly" and are readily available.

Until recently, a physician had to make arrangements through a medical librarian to do a computer search. In the last five years, more end users have become involved in designing and performing their own searches. Many regional medical libraries offer courses in using the NLM databases. Through use of these databases, a physician can choose his own search strategies to obtain bibliographic information. Thus, specific questions can be asked and citations reviewed. Through the use of a local database management program, a physician can link the retrieved article with a specific patient or problem for future study.

Information communication with other practitioners is available through computer "bulletin boards." Such electronic mail programs, available

Table. Examples of software for computer-generated CME.

Drug Interactions

1. *Drug Interactions III*, Richard Jeffries, Quaker State Software, 4600 Custer Drive, Harrisburg, PA 17110. Relatively inexpensive, easy to use two-diskette, IBM-based system to check for drug interactions, drug-food interactions.

2. *Medi-Span*, 5980 W. 71st Street, P.O. Box 68875, Indianapolis, IN 46268-0875. Formerly known to many as Mediphor, the drug interaction, adverse reaction guide from Stanford University now is available on six floppy disks. More expensive than Dr. Jeffries's program and geared to the pharmacy or library.

Simulation Software

1. *DiscoTest*, *Scientific American*, 415 Madison Avenue, New York, NY 10017. An interactive computer-based, case-related CME available on an annual subscription basis with quarterly distributed AMA category 1 credit case problems. Available for IBM and Apple. Straightforward and easy to use, best used as a companion to *Scientific American's* reference stories on medicine at an additional cost.

2. *Massachusetts General Hospital Continuing Education Programs*, available on AMANet, American Medical Computing Ltd., 535 North Dearborn Street, Chicago, IL 60610. This is a "pak-man" CME, but without the graphics. Allows CME, at one's own pace, at whatever time is convenient.

On-Line Bibliographic Reference Systems

1. *National Library of Medicine*, MEDLARS Management Section, 8600 Rockville Pike, Bethesda, MD 20894. References available for a wide variety of subjects.

2. *Dialog Information Services*, 3460 Hillview Avenue, Palo Alto, CA 94304. A supermarket of bibliographic databases including MEDLARS, Excerpta Medica, medical, sociological, and marketing. Over 100 databases to search, and costs vary with the database selected.

Electronic Mail

1. *Compuserve*, 5000 Arlington Centre Boulevard, Post Office Box 20212, Columbus, OH 43220. Primarily geared to the nonprofessional, recreational user. Many user groups are represented on bulletin boards, such as the American Association for Medical Systems and Informatics and other medical information sources. Contains headlines from the Associated Press, St. Louis Dispatch, weather, theatre, movie reviews, and games.

on Compuserve, the Source, and AMANet, allow a physician to pose questions and have such questions reviewed by a large number of physicians accessing the same bulletin board. A physician, perhaps reluctant to bother another physician, may receive information from a large number of sources, many of whom may have experienced similar problems and discovered solutions for them. These consultations are akin to the "corridor consult" and supplement the informal communication which classically oc-

curs in hospital hallways, parking lots, and nursing stations.

Medical simulation software allows the computer to be used as a teaching device. *Scientific American* publishes a continuing medical education program DiscoTest, which presents the physician with clinical cases and allows physician interaction with the computer. Massachusetts General Hospital has organized a collection of over 20 such case-related courses, designed to teach efficient diagnosis and treatment. With these kinds of simulation software a physician logs on and interacts with a computer making diagnostic and management decisions. At the same time, the computer monitors the physician's progress and provides feedback. The recent reintroduction of the video disk, specifically the computer-linked video disk, has opened two broadened markets for simulation education. Still as motion pictures can be added to the information presented to the physician-trainee to construct a complete patient management program. Courses already have been developed via computer-linked video disks in the area of CPR training and AIDS.

Problem-specific programs are available. At least two office-based computer programs are available to provide a physician with quick answers to questions about drug interactions. A physician merely enters the names of drugs a patient is receiving and the computer searches for reports of interactions. A physician who routinely uses such a program builds his knowledge base while protecting patients. Senior citizens tend to take a large number of prescription and nonprescription drugs. Maintaining a patient "profile" by cross-checking for drug interactions will protect the patient from adverse reactions and protect the physician from possible medical liability problems while adding to the personal knowledge base.

Physicians classically file office records by name or by a number system. It is rare that a physician in a clinic, or hospital, indexes patients by clinical problems or diagnosis. As more physicians develop computer-based systems in their offices, the linking of patient problems and CME will become more available. Case linkage of patient names and clinical information can be accomplished easily with an office-based computer. The physician then can analyze and better understand clinical problems and plan for more effective continuing education.

The place of the computer in the medical office is secure. The computer originally found its way into medical practice primarily as a revenue generator (billing system); however, computer-based continuing education rapidly is becoming a reality. In the future, it is likely that educational purposes may supplant billing as the primary focus for the office-based computer. Through computer-based CME, individualized, effective CME may be achieved.

The Pharmaceutical Industry and CME

ROBERT HELLER

The pharmaceutical industry devotes an enormous amount of time and effort in the area of research and development, bringing about newer and, hopefully, improved treatments to the benefit of patients. The process of drug development, from preclinical testing through clinical trials, and further through toxicological analysis, can be painstaking, time-consuming, and expensive. To make the step from development to marketing requires effective physician education. Because physicians ultimately are the dispensers of drugs, at least with respect to prescription items, proper physician education, as regards benefits and risks, is an essential ingredient to success in such pharmaceutical endeavors. How best can this information be communicated and disseminated?

Numerous communication methods have been utilized by pharmaceutical companies in their efforts to educate physicians. These take the traditional forms of published material, such as journal articles, drug compendia, advertising, and "detailing" via pharmaceutical representatives. Also, many pharmaceutical concerns sponsor or coordinate group educational programs or employ electronic media in the form of audio or video cassettes or computer programs for self-directed learning.

TRADITIONAL COMMUNICATIONS

Routine drug information conveniently is delivered using traditional media formats. Conventional media include formulary guides, annotated prescribing information, journal reprints, informational advertising, videocassettes, and calls from trained representatives.

Robert Heller is in the Department of Public Affairs, E.R. Squibb and Sons, Inc. Requests for reprints may be addressed to Mr. Heller, E.R. Squibb and Sons, Inc., P.O. Box 4500, Princeton, NJ 08543-4500.

Let us look at these communication modalities more closely. The manufacturer places high value on the information to be distributed. Media carefully are selected for convenience, credibility, currency or circulation, appropriateness, and costs.

In an age of electronic media, the print media are senior citizens: they are reliable, instructive, far-reaching, and authoritative. In journals with editorial boards and publishing staffs that carefully review editorial content, a researcher's study undergoes withering scrutiny before it is accepted for publication. Such journals can continue in their centuries-old technology for good reasons: they are user-friendly and substantive, and they suggest permanence, for better and worse. Best of all, the journal is a reflective forum that invites display of the eloquent, or at least, the well-argued proposition. At the foundations of scholarship, journals have been boosted by computer-assisted searching techniques that are simplifying access and data retrieval. More successfully than other media and critical to their ability to thrive, journals have been able to target small sectors of audiences, specialty by specialty, an attractive feature to both readers and advertisers.

Informational advertising emphasizes the high points of research and especially is useful for summarizing data quickly and early in the life of a product. Advertising is expensive to develop, produce, and schedule. Worse, it must vie for an audience in densely represented arenas and, at times, it can be difficult to determine which advertisements are effective.

Like advertising, direct mail is a nonpersonal selling medium, an overt attempt to persuade the physician to change prescribing habits. This is not to say the information is not valid or instructional, but it may be limited in its perspective. Done poorly, a

direct mail program contributes to the clutter; done well, such a program will engage the physician by offering timely and clinically useful information.

All these efforts to communicate in various ways enhance information presented by the manufacturer's professional representative. Representatives typically undergo months of intensive training, followed by a pilot experience in the field, only to return periodically for additional training phases. Armed with clinical reprints, videocassettes, laptop computers, and other tools, the well-trained and experienced representative can be a valuable source of information for the practitioner.

NONTRADITIONAL COMMUNICATIONS

Most traditional methods of communication are transacted through the comfortable, nonthreatening, but time-consuming, modality of reading. Everyone reads, of course; but not everyone has time to read. Also, the process of acquiring information by reading is linear, and difficult to compress. Possibly the greatest drawback of reading-based modalities is their one-way flow of information: no matter how imaginative the conception and design of such programs, it is extremely difficult to create a sustainable dialogue with the reader.

Enter high technology modalities and their promise to resolve the shortcomings inherent in the reading process. High-technology modalities, such as video, teleconferencing, and narrowcast television, are image-based. A simple videocassette, for example, more easily can demonstrate a surgical or examining procedure than even the most graphic of pictorial atlases. Most attractively, too, these methods compress time. There are limits to what can be expected from an image-based technology. Demanding tasks such as intensive memory training may not be appropriate: consider a video of Gray's *Anatomy*, for example. Still, the capability of compressing time is a killing advantage in an age when each day brings exponentially more to know and do.

Another important advantage of high technology communication that sets it apart from traditional, reading-based media is the ability to elicit participation from its audience. Computer-driven programs such as videodiscs offer the advantages of being image-mediated and of being able to draw the viewer into the learning process. Such interaction dramatically increases usership and improves memory retention. For these reasons, and for the fact (illusion) that they seem somehow more authoritative than traditional formats, videodiscs are likely to gain in popularity. The use of videodiscs by some examining boards is worth noting. Disadvantages associated with their use include the demands on computer-memory and the costs entailed with burning new discs to revise or update information. Also,

unlike videocassette recorders (VCRs), the necessary hardware is not yet widely available.

Consider that some media which presently popular (computers and VCRs) were scarcely thought of only ten years ago. Yet, newer technologies arrive each day (camcorders, optical scanning and optically- and voice-driven computers), bringing innovations to older methods as well. Telecommunications is a case in point. Telephone satellite teleconferences are effective, but not necessarily cost-effective, ways of transmitting edge information simultaneously to multiple remote sites, with the added benefit of interaction between faculty and audience. Electronic mailboxes have arrived—only to be instantly supplanted by phenomenally ubiquitous fax machines. The time frame for peering into the future apparently shrunk from centuries to months.

GROUP EDUCATION

With the exception of teleconferencing, the scribed methods of disseminating information have been individualistic, one-on-one, doctor and patient. Group education methods offer different benefits. When experts from major research institutions conduct studies that will change the course of medical history, we select the symposium format as being more suitable for disseminating their findings. Panels of researchers can announce, focus, and provide perspective for the most current thinking about disease states and their management. We have found symposia to be useful as forums for the exchange of views between the practitioner in the trenches and acknowledged experts in a given field of research. Symposia further serve as a means of feedback that enables us to survey the educational needs of the audience and modify the direction of our efforts responsibly.

The organization and administration of a symposium is a considerable and expensive undertaking. Innumerable logistical details must be worked out. Schedules must be accommodated and arrangements made for faculty and audience, for hotels and transportation, for meeting room availability and refreshments, and for audio-visual hookups and support. The undertaking of such a complex project may be justified when it serves the purpose for which it is intended: the publication of revolutionary knowledge to those whose professional efforts require such knowledge.

CONCLUSION

The pharmaceutical industry has an important responsibility in physician continuing education. Pharmaceutical companies should strive to maintain objectivity and credibility to optimize the effectiveness of their contribution. ■

A Time of Change for CME

RICHARD E. DIXON, MD

Continuing medical education (CME) is big business. In the United States, an estimated 10,000 persons are significantly involved in providing CME for physicians, and the annual expenditures for CME have been projected to be over \$10 billion per year.¹

The need for CME activity is obvious. Biomedical literature is expanding rapidly. Worldwide, several thousand new articles are published on an average every day. Every physician needs to stay current, but no individual can survey even a fraction of the flood of new information. Well-designed educational programs offer the prospect that the pertinent advances can be synthesized and learned. But do formal CME programs meet this need? Do physicians really learn from the multitude of educational offerings?

CME UNDER ATTACK

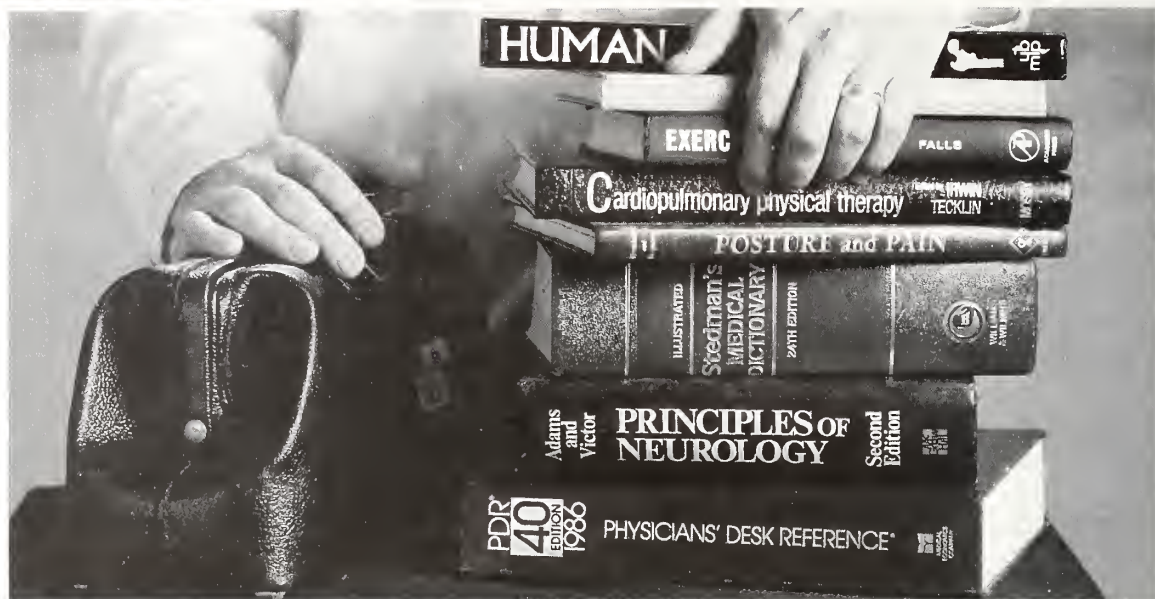
The effectiveness of CME programs long has been questioned, and many investigators have attempted to evaluate their effect, but few scientific studies have been able to demonstrate that they have significant value. Haynes and colleagues system-

atically reviewed 248 of these studies and found that only a minority were sufficiently well designed to evaluate the effectiveness of educational programs.² Although they concluded that CME can change physician behaviors, they noted that few studies even attempted to determine whether patient care improved as a result of educational programs.

Professional educators especially have been critical of physician CME. They assert that many programs are badly designed, irrelevant, and ineffective. Few organizers of CME programs seek to determine what students already know or what they need to know; more often, course content is determined by the teacher's expertise. Critics contend that medical educators typically treat students like children, not like adults. Lectures dominate, and physicians sit passively as a visiting expert lectures about the subjects that interest him. All too often, the members of the audience play no active role in the educational experience at all. The scene is reminiscent of our worst memories of adolescent schooling.

These critics also point out that adults learn in different ways. For some, lectures are effective. But for many others, textbook reading, small-group discussions, or interactive computer or video programs are more useful. Many physicians most vividly remember the lessons learned from patients and col-

Dr. Dixon is medical director, Helene Fuld Medical Center, Trenton, and chairman, Committee on Medical Education, AMNJ. Requests for reprints may be addressed to Dr. Dixon, Helene Fuld Medical Center, Trenton, NJ 08638.



leagues as they managed challenging cases. Nonetheless, formal CME programs almost always follow the traditional lecture format.

Many physician-students seem to agree. Surveys of physicians who do not participate in CME programs find various reasons for nonparticipation (Table).² These nonparticipants often claim that educational programs are costly and inconvenient, are irrelevant to their perceived needs, or provide an inefficient way to learn new information.

Continuing medical education for physicians has become increasingly commercialized. Pharmaceutical firms and device manufacturers now play a dominant role in subsidizing educational programs. Guest lecturers abound whose honoraria and expenses are paid by firms that seek to influence physicians' prescribing practices, and those honoraria typically are far more generous than independent organizations, such as hospitals, can pay. As a result, many excellent teachers derive considerable income from providing lectures sponsored by commercial firms, and some refuse to accept invitations from organizations that are unable to match the fees offered by industry. Fortunately, it still is rare for an industry-sponsored speaker to be corrupted by his sponsor, but it generally is recognized that a lecturer who is critical of a sponsor's product will not be subsidized by that firm again.

Flagrant hucksterism is not the greatest threat from industry sponsorship of CME. A more important threat—and a more subtle one—is that the drug and device industries will set the educational agenda for physicians. If hospitals and other traditional suppliers of CME become overly dependent on industry for financial support for programs, it is likely that educational programs will be offered only for those topics where there is a commercial interest. It is easy to organize programs, find speakers, and obtain

financial support for meetings that address treatment of hypertension, use of new broad-spectrum antibiotics, or the management of arthritis. It is far more difficult to obtain support for topics that are equally important but that have little commercial appeal such as acid-base and electrolyte problems, anemia, organic brain syndromes, or medical ethics. Thus, topics that are both important and interesting become educational orphans.

CME INNOVATION

Despite these criticisms, it is apparent that physicians do learn and do change their practices. New technologies and treatments are embraced rapidly, and these changes only can have occurred because physicians have learned new information. How else can we explain the radical changes that have occurred in the use of radiologic imaging techniques in medical and surgical treatment of peptic ulcer disease, and in the widespread and rapid adoption of countless new medications shortly after they are introduced?

If physicians do learn and change their practice patterns, how does that learning occur?

Several approaches to physician education appear to be highly effective. Among the most successful are those used by pharmaceutical firms. Articulate and persuasive sales representatives provide individualized education to physicians in a nonthreatening manner. They place few obstacles to education. Instead of requiring the physician to attend a conference, they visit the office. Instead of lecturing, they discuss. These pharmaceutical representatives have been so effective in promoting the use of new antimicrobial agents, for example, that many hospitals have major problems with antibiotic drug-resistance and skyrocketing pharmacy budgets. A few hospitals have attempted to counteract pharma-

able. Reasons why physicians do not participate in CME activities.

- Difficult to leave practice responsibilities.
- Perceived lack of relevance.
- Inefficient learning: other sources better.
- Demographics.
 - Men
 - Foreign medical graduates
 - Not board certified
 - Not member of hospital staff
- Cost, inconvenience, and distance to travel.

tical education by restricting access of sales representatives to hospital-based physicians and residents. More creative and innovative hospitals have opted the techniques of the pharmaceutical sales representatives and have hired equally bright, attractive, pleasant, and nonthreatening staff to "counter-detail" the use of new medications. Hospitals using this approach have reported striking success.³

The Tennessee Medical Society adapted the approach of the pharmaceutical industry to educate physicians about the use of benzodiazepine sedatives. Using Medicaid prescription records, Ray and his colleagues identified a group of physicians who tended to prescribe sedatives more often than expected.⁴ These frequent users of benzodiazepines tended to be elderly, to be located in rural areas, and to have graduated from medical schools earlier than physicians who used the agents less frequently. Their characteristics were typical of physicians who rarely participate in formal CME programs. In a randomized, controlled, prospective trial, a sample of these physicians was visited by physician colleagues who were assigned to teach about use of sedatives using a nonthreatening, individualized approach. The teachers found that many of the physicians knew they prescribed excessive amounts of sedatives but had no effective strategy to deal with anxious patients and, furthermore, did not know how to detoxify patients who had been started on treatment. Among the group of physicians who were unseated and provided with specific protocols for treating anxious patients and detoxifying those who were habituated, the use of sedative agents declined markedly.

The surgical wound infection literature provides additional clues about effective physician education. Several studies have shown that individual, confidential, and anonymous feedback about surgical wound infection rates to individual surgeons leads to significant reductions in wound infection rates among those surgeons with the highest infection incidence.⁵

Both of these successful educational efforts emphasized individualized education directed

towards the perceived needs of the students. Another innovative approach, Physician Initiated Continuing Medical Education (PICME) takes the next logical step: The physician decides what he wants to learn and designs his own educational program to achieve that objective. Consider the traditional options available for the physician who wants to learn a new technique such as colonoscopy. He could attend a course, but such courses rarely provide a sufficient amount of direct, hands-on experience with the technique to assure competence. Alternatively, he could enroll in a "miniresidency" in a teaching hospital or medical school. Few such formal programs exist, and, where they do, they usually require the physician close his practice during the training. Finally, he either could teach himself or ask a colleague to provide supervised training, but neither of these informal approaches assures that he will achieve the necessary skills or that he will obtain formal certification for his training. PICME offers a better option.

PICME is a formal, coordinated program that allows the physician to gain the specific knowledge and training needed in a supervised setting, but it allows the physician to design that educational experience in a convenient and practical manner. A PICME program assists the physician to define his educational needs, helps him identify an appropriate teacher, confirms that the educational objectives have been met, and provides category 1 CME educational credits for the experience. For example, the physician who wants to develop skills in colonoscopy might specify that he wants to perform 50 colonoscopies under supervision. An appropriate teacher would be identified, would agree to provide the supervised training, and would attest to the student's participation and competence at the completion of the training. The student and teacher would agree upon mutually convenient times for the educational sessions, and the student could schedule those times so that a minimum amount of time is lost from the practice. The Academy of Medicine of New Jersey recently has been approved to coordinate PICME programs and is the sole such provider of these programs in the state.

Video and computer-based instruction are being increasingly used in many fields, and they should be both effective and appealing for physician education. Videocassette programs can be used at a physician's convenience and do not require travel or schedule changes. These programs can bring the best teachers in the country into the offices and homes of every physician. Unusual patients and examples of rare diseases can be shown in detail. Complex surgical procedures can be demonstrated quite effectively and can be reviewed as often as necessary by the student to learn the techniques used. Sophis-

ticated computer-based programs can provide realistic patient-management simulations and can allow the physician to be an active participant in the education. By combining computer and video technologies, as is possible with the laser videodisc, an educational program can be designed that allows the physician to see a patient, design a clinical evaluation, plan a management strategy, and see the effects of his decisions immediately. Despite these obvious advantages, these techniques have had little impact on medical education. Few sophisticated programs have been developed, and, even when they are available, they have not been widely used.

We can only speculate why video and computer programs have not been more successful as educational vehicles for physicians. First, the technologies required to display these programs often have had several competing standards. Apple offers two standards for its computers, the older Apple II and the newer Macintosh, and neither is compatible with computers based on the IBM standard. Only in the past several years has it been obvious that VHS would become the dominant videotape standard. Laser videodisc players are expensive, and manufacturers use different proprietary technologies to record programs. Thus, a program recorded for one videodisc player is unlikely to work on a player distributed by another manufacturer. Second, such programs are expensive to produce and distribute, and the traditional purveyors of educational programs, the pharmaceutical industry and medical schools, have not invested sufficient resources in these techniques to build a library of appealing programs. Finally, medical educators apparently have not considered these technologies to be legitimate educational techniques. Physicians receive category 1 CME credits for merely attending a lecture, even if they pay no attention. In contrast, category 1 credits are provided to users of video or computer technologies rarely and, even then, only after physicians complete tests to prove they actually participated in the program.

CONCLUSION

Physicians do learn new information. And, physicians do change and improve their practices. Nonetheless, time, money, and effort currently spent to support today's continuing medical education pro-

grams could be better directed.

First, medical educators should recognize that traditional lecture format is not necessarily the way to teach every topic. Interactive teaching techniques such as computer-based instruction, small group seminars, or individualized encounters using a PICME model are much more likely to teach medical judgment and decision-making skills than passive learning experiences such as lectures. Furthermore, although some physicians learn readily in lectures, many others learn more efficiently in other settings. Thus, medical educators should encourage the development of varied educational techniques. Since programs that offer category 1 CME credits generally are considered to be especially worthwhile, these alternative educational programs should be approved for category 1 credits whenever possible.

Second, physicians should reclaim control of their educational agenda. Individual physicians rarely determine the content of medical education programs but instead have allowed others to decide what they will be taught. Pharmaceutical firms and device manufacturers have an appropriate role in medical education, and that role includes educating physicians about the benefits of their products. If current trends continue, these commercial interests will so dominate educational programs that other important medical topics will not be addressed. Every organization that offers educational programs for physicians should strive to achieve a reasonable balance between programs that promote new drugs or devices and those that address topics that have no commercial link.

Finally, the advances in biomedical knowledge likely will continue to increase logarithmically, and physicians will have increasing problems remaining up to date. My introductory lecture in medical school, delivered by the dean, said, "Welcome. I am of what we will teach you in the next four years is wrong. Unfortunately, we don't know which half is wrong. He was mistaken. More than half of what my class was taught was wrong. If we hope to learn what we do not know, to relearn what we have forgotten, to unlearn what we were mistakenly taught, we must depend on effective continuing medical education programs. We must make certain that those programs are fit for the task. ■

REFERENCES

1. Felch WC: Continuing medical education in the United States: Enterprise in transition. *JAMA* 258:1355-1357, 1987.
2. Richards RK, Cohen RM: Why physicians attend traditional CME programs: Supplement to a CME research report. The Upjohn Company, June 1981.
3. McDonald R: Personal communication, Sidney, Australia, 1984.
4. Ray WA, Blazer DG 2nd, Schaffner W, et al.: Reducing long-term diazepam prescribing in office practice: A controlled trial of educational visits. *JAMA* 256:2536-2540, 1986.
5. Cruse PJ, Foord R: The epidemiology of wound infection: A ten-year prospective study of 62,939 wounds. *S Clin North Am* 60:27-40, 1980.

NOTEBOOK

TRUSTEES' REPORT

A regular meeting of the Board of Trustees was held on Sunday, July 16, 1989, at the executive offices. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows.

Report of the President . . .

Professional Unity . . . Noted that Dr. Hirsch reiterated the point that MSNJ is the appropriate organization for medical society and Dr. Harold S. Yood, representing the Hospital Medical Staff Section and Dr. George J. Summaier, representing the medical specialty societies, will sit at Board table at Board meetings.

Special Dates . . . Noted the following dates: September 13: Insurance Company Report and Seminar; October 4: Board legislative sessions; November 15: Conference of Presidents; March 9-10: Strategic Planning Retreat.

Executive Committee Dates . . . Noted the following: July 26: Meeting with State Health Commissioner Coye; July 26: meeting with New Jersey Hospital Association; September 17: meeting with Congressional delegation.

Guests at Future Meetings . . . Noted that Congresswoman George Roukema will address the Board meeting on September 17 and Dr. James Todd will attend November 19 Board meeting.

Appointment of AMA Delegation Officers . . . Congratulations were extended to Drs. Manzoni and Riggs, as chairman and vice-chairman of the AMA delegation, respectively.

(6) Participation of Women Physicians in Organized Medicine . . . Noted that the Essex County Medical Society and all county societies have endeavored to locate women physicians willing to serve; Anita Falla, MD, from Essex County, was elected to serve as Judicial Councilor, First District.

(7) AMA Program To Evaluate American Health Care System . . . Announced appointment of Dr. Robert J. Weierman to the new AMA program to evaluate the American health care system.

Report of Executive Director . . .

(1) MSNJ Paid Membership . . . Noted that as of June 30, 1989, paid memberships totaled 7,255.

(2) MSNJ Financial Statements . . . Noted that the audit of MSNJ's financial statements for the fiscal year ending May 31, 1989, is being completed.

(3) AMA Review of Physician Payment Review Commission (PPRC) . . . Received for information copies of the executive summary and full report on the AMA's review of PPRC.

(4) S-2936—Medical Discipline and Licensing . . . Noted that MSNJ will seek one further amendment to this legislation.

(5) Medical Malpractice Surcharge . . . Noted that the matter still is in the proposal stage and MSNJ and MIENJ have refiled all previous comments.

(6) Medical Waste . . . Noted that MSNJ is involved in opposing the program and registration fees in the current form.

(7) MSNJ versus State Board of Physical Therapy . . . Noted that

the case has moved to the New Jersey Supreme Court.

(8) MSNJ versus Ombudsman . . . Was advised that Mr. Abrams proposed to repeal existing administrative rules and adopt the administrative rules revised by his predecessor; the deadline for submission of comments is September 5, 1989.

(9) Medicare . . . Noted that the United States House Ways and Means Committee agreed to impose arbitrary limits on expenditures for services to Medicare patients and physicians were urged to oppose Medicare expenditure targets. Noted that MSNJ staff and the chairman of the Committee on Public Relations will investigate feasibility of using public relations funds to deal with this issue.

(10) Burdette Tomlin Memorial Hospital Obstetrical Services . . . Agreed to wait until a response is received by Mr. Maressa from the deputy commissioner of health concerning actions in the maternity unit of Burdette Tomlin Memorial Hospital before acting on this matter.

UMDNJ Report . . . Noted the following items from Dr. Paul F. Larson, senior vice-chairman of academic affairs: UMDNJ's affiliation with Our Lady of Lourdes Medical Center, Camden; and the new Jemstar aeromedical rescue system for New Jersey.

AMA Annual Meeting . . .

1) AMA Dues . . . Noted no dues increase for the coming year but an anticipated \$25 to \$35 increase for the next year.

(2) **Resolutions Introduced by New Jersey . . .** Noted the following resolutions and their actions: resolution introduced by the New Jersey delegation on sexual exploitation was not adopted, yet Report B of the AMA Council on Ethical and Judicial Affairs was adopted; substitute resolution submitted by the AMA reference committee on removal of discriminatory or biased provisions toward non-participating physicians was adopted; a substitute resolution concerning mandatory Medicare assignment or determination of fee levels was discussed and first section of the substitute resolved was sent to the AMA Board for action and the second portion was adopted; resolution on Medicare participation was adopted as amended, calling for the AMA to petition Congress to end the Medi-

care "participation" program because it is not in the best interests of physicians or their patients, calling the AMA to oppose discriminatory policies regarding Medicare "nonparticipants" being used by the government, and calling the AMA to support the right of every physician to make his own decision regarding participation; resolution on social admission denials was referred to the Board of Trustees for action and report; in lieu of the New Jersey resolution on collective bargaining, the AMA House adopted Board of Trustees Report YY updating the AMA's efforts to assist physicians and medical societies in negotiations with others; substitute resolution on ICD-9-CM coding was adopted; substitute resolution on expenditure targets was adopted, calling for the AMA to reaffirm its willing-

ness to participate in efforts to control the cost of Medicare in a manner that preserves the quality and availability of health care to Medicare recipients and to urge Congress to assure a high priority health care for Medicare patients; develop a mechanism to channel Medicare's finite resources to the patients with greater financial need, and to require a proportionately larger financial contribution by the more affluent toward their own health care, and reduce the cost of defensive medicine. (3) **MSNJ Candidate for AMA Board of Trustees . . .** Voted unanimously to endorse the candidacy of Dr. Palma Formica to the AMA Board of Trustees. **Committee on Membership Services . . .** Approved the following: That the Medical Inter-Insurance Exchange of New Jersey be formally

NEW JERSEY MEDICINE

presents

Continuing Medical Education

The 14 contributing authors of this special issue discuss the present condition of continuing medical education and the future goals of CME in New Jersey.

Single copy: \$5

Ten copies or more: \$4

**Send check to: NEW JERSEY MEDICINE
Two Princess Road
Lawrenceville, NJ 08648**

used as a product of the Medical Society of New Jersey, and be authorized to use the MSNJ logo.

Committee on Medical Aspects of Sports . . .

Comprehensive Substance Abuse Program . . . Approved the following:

That MSNJ suggest that a comprehensive substance abuse program developed by the Department of Health to address drug and alcohol problems, including the issue of anabolic steroids. (Although initial emphasis of the program should be education and rehabilitation, in those particular situations where a particular group feels that testing is indicated, a comprehensive program of education, testing, and counseling should be established and a policy be written prior to the institution of testing. Testing by itself is not an appropriate program, should not be punitive in nature, and should only be a part of a program which includes education, cognition, and subsequent treatment where the problem exists.)

That appropriate resources should be made available through the Department of Health to accommodate any testing deemed necessary.

That a pilot program be instituted in a selected district to be managed by the Department of Health.

That anabolic steroids be classified as controlled dangerous substances.

Governor's Proposal To Eliminate Physical Education from High School Curriculum . . . Approved the following:

That MSNJ acknowledge Governor Kean's concern for expanding high school curricula in the areas of physical science, mathematics, computer science, and English. (These needs should be addressed by considering extension of the school day by at least one or two classroom periods.)

That physical education should be mandatory throughout all four years of high school.

Committee on Physicians' Health . . . Approved the following:

That the medical director be authorized to approve grants of up to \$1,000 without first obtaining approval

of two MSNJ executive committee members. (Reporting of all grants issued still will be made to all members of the Physicians' Health Program Board of Directors which includes two members of the MSNJ Board of Trustees.)

That the Board of Trustees authorize a \$2,000 grant to a Union County physician to assist in the payment of his treatment.

Committee on Utilization Review Systems . . .

(1) PRO/New Jersey Task Force—Resolution #3 (1989) . . . Was advised that no action was necessary on this resolution that directed MSNJ to establish a PRO New Jersey task force similar to the one established by the Washington State Medical Association, since that one is patterned after the New Jersey program.

(2) Utilization Review Organizations . . . Approved the following:

That MSNJ advise the Department of Health to designate only one utilization review organization per hospital.

Committee on Medical Education . . . Approved the following:

That an invitation be sent to the PRO, hospital medical staffs, Committee on Physicians' Health, State Board of Medical Examiners, Academy of Medicine of New Jersey, and UMDNJ, from the president of MSNJ asking them to attend a meeting with the Committee on Medical Education.

JEMPAC . . . Noted the following: funds for JEMPAC and MedAc total \$111,842.18; a JEMPAC solicitation letter was approved and will be sent to MSNJ members; voter registration forms and *Elections Made Easy* were provided to the JEMPAC Board; a candidate questionnaire is being devised by Clark Martin for candidate support for the general election; and JEMPAC membership list will be sent to members of the Board, hospital medical staff section, and presidents of county medical societies.

Unfinished Business . . . Urged physicians to review the proposed changes and convey opinions to MSNJ on the CDS regulations by the Department of Health as soon as possible.

New Business . . .

(1) Status of Reimbursement to Physicians for Indigent Care . . . Unanimously accepted the following:

(a) That the uncompensated care issue be brought up at the July 26 meetings scheduled for the executive committee of MSNJ, first with New Jersey Health Commissioner Coye, and then with the executive committee of the New Jersey Hospital Association.

(b) That testimony be given by MSNJ representatives to the existing Task Force on Uncompensated Care.

(c) That MSNJ appoint its own Task Force on Uncompensated Care.

(2) Medicare Scam . . . Was alerted to a scam involving Medicare purchase of home and health care products from a Philadelphia-based company.

Correspondence . . . Received the following: (1) from Molly Joel Coye, MD, MPH, regarding Resolution #14 (tanning salon legislation) and expressing thanks for MSNJ's concern on this issue; (2) from Michael B. Grossman, DO, chairman, medical director, Search Committee, State Board of Medical Examiners, concerning a medical director for SBME; noted a letter will be written expressing disappointment because Dr. Grossman's letter did not address the intent of MSNJ's offer—to have an opportunity to comment on candidates prior to their appointment to SBME. □

UMDNJ NOTES

Blood transfusions are unnecessary in many cases, according to a study by a surgeon at UMDNJ's Camden campus. The study, to be published in the *American Journal*

of Surgery, found that many elective, or nonemergency, surgeries can be performed safely without preoperative transfusions on patients whose hemoglobin count is as low as 6 grm/dl—well below the previously required count of 10 grm/dl. The hemoglobin count measures the amount of oxygen-carrying substance in red blood cells. The findings will help decrease the cost of surgery. Blood transfusions have become increasingly expensive because of the threat of blood contaminated with HIV and other viruses.

The study was conducted by Dr. Richard Spence, an associate professor of surgery at UMDNJ-Robert Wood Johnson Medical School, Camden. Dr. Jeffrey Carson, assistant professor and chief of the Division of General Internal Medicine at UMDNJ-Robert Wood Johnson Medical School, also participated. The study found that the human body is strong enough to withstand most elective surgery without mandatory preoperative blood transfusions. Also, surgeons now can better control bleeding during operations. In addition, the use of an autotransfusion device that recycles blood to the body decreases the need for transfusions.

Researchers at UMDNJ-New Jersey Medical School are testing a synthetic growth hormone stimulator to determine whether it can increase the height of children who are short for their years. The therapy, not yet available to physicians, is designed to stimulate a child's pituitary gland to produce the hormone that influences growth. This technique could replace the current use of a synthetic hormone that stimulates growth but that has adverse side effects. Dr. Robert Rapaport, associate professor of clinical pediatrics at the medical school, is directing the study. It is hoped that the new drug will provide a more natural way of treating children with growth hormone deficiency.

The drug under study—a new growth hormone-releasing factor called GRF—was developed by Hoffmann-La Roche Inc. of Nutley.

UMDNJ has initiated central New Jersey's mobile outreach unit to serve the mentally ill homeless in eight Middlesex County towns. Operated by the UMDNJ-Community Mental Health Center, Piscataway, the unit travels to Dunellen, Edison, Highland Park, Metuchen, New Brunswick, North Brunswick, Piscataway, and South Plainfield to find homeless individuals who require mental health care, social services, and transitional housing. The program—the Clinical Care Management/Mobile Outreach Units—is funded by a three-year, \$600,000 grant from the Robert Wood Johnson Foundation of Princeton.

Newly diagnosed Parkinson's disease patients who have not yet been treated with the drug Sinemet® (levodopa) are being enrolled in a clinical trial study sponsored by UMDNJ-Robert Wood Johnson Medical School. The aim of the study is to determine how to best administer the drug to stop motor fluctuations (flailing of limbs). Sinemet® usually is administered at specific intervals rather than in a constant daily dose through sustained release of the drug. The method by which Sinemet® usually is given may play a role in these motor fluctuations. If this hypothesis is correct, then giving a more constant daily levodopa load, avoiding large concentrations, may help or delay these fluctuations.

Patients will be followed by a UMDNJ neurologist for five years in cooperation with the patient's regular physician. Patients who develop fluctuations will have the dosage of the drug adjusted as part of the treatment. There will be no charge for drugs or treatment. The deadline for enrollment is January 31, 1990. For further information, call Dr. Jacob Sage or Dr. Margery

Mark at 201/937-7731. □ Stan S. Bergen, Jr., MD

MSNJ AUXILIARY

Are you registered to vote? Many physicians are not! Concerned with the fact that not all physicians are registered to vote, MSNJ has enlisted the Auxiliary support in developing a mechanism to promote voter registration. The Auxiliary has responded by proposing a step-by-step plan for each county auxiliary to follow during "Physician Voter Registration Week," September 17-23, 1989.

The operation will take place at hospitals throughout the state. Auxiliary volunteers will obtain registration applications and absentee ballot requests from the board of elections and have them available for physicians at registration booths located at strategic spots in each hospital. Auxiliary members not only will disseminate the forms, they also will offer to return them to the board of elections. In addition, physicians will be encouraged to take forms home to any unregistered family members, including absentee ballots from college-age children.

Hopefully, "Physician Voter Registration Week" will make registering as easy as possible for the busy doctor, and at the same time, encourage medical families to get out and vote for candidates who have a record of support from the Medical Society-approved legislation—regardless of party affiliation.

In June, during the four-day meeting of the AMA House of Delegates, New Jersey Auxiliary members participated in a national phone blitz to protest proposed expenditure targets (ETs). Delegates made over 700 calls to congressmen and administration officials exhorting them to vigorously oppose proposals to ration Medicare in the guise of expenditure targets. In New Jersey, individ-

county members responded to an SNJA legislative alert by calling writing to legislators. Some county auxiliaries contacted senior citizen groups and urged them to send their representatives a message: Don't balance the budget on the backs of the elderly and disabled. Rationing our health care is an unacceptable burden. Please, no ETs. □ Marion H. Geib

NEW MEMBERS

MSNJ would like to welcome the following new members:

Atlantic County

David B. Handel, MD
 Harry J. Kaufman, MD
 John J. Santoro, DO
 Mukesh J. Shanker, MD
 Pranjan G. Trivedi, MD

Bergen County

Arsh Chander, MD
 Martin Davis, MD
 Martin R. DeMais, MD
 Michael J. Harris, MD
 Yury M. Kashkin, MD
 Bradley S. Kaufman, MD
 Mohra M. Munoz-Silva, MD
 Piero Neckles, MD
 Alimar S. Prabhu, MD
 Alan D. Sehgal, MD

Burlington County

John W. Laub, MD
 Francis P. Sutter, DO

Camden County

John E. Agens, MD
 Gary G. Berger, DO
 Edward J. Doolin, MD
 Sue S. Friehling, DO
 Elizabeth L. Helfer, MD
 Anthony Masciarelli, DO
 Edward N. Orel, MD
 Luis J. Raso, MD
 Elaine L. Reed, MD
 William J. Robertello, MD
 Mark R. Zaontz, MD

Cumberland County

Robert J. Shatkin, MD

Essex County

Joseph Benevenia, MD
 Eugene J. Cherny, MD

Elaine Douglas, MD
 Makram M. Erian, MD
 Joseph M. Koziol, MD
 Theresa M. Kriston, MD
 Matthew J. Marano, Jr, MD
 Thomas M. Shea, MD

Gloucester County

Timothy S. Pilla, MD

Hudson County

Jesus R. Alfonso, MD
 Luis A. Espina, MD
 Feridoun Rezai, MD
 Peter A. Rossi, MD
 Yogini J. Shroff, MD
 Arm W. Won, MD

Hunterdon County

Dein M. Shapiro, MD

Mercer County

Debra J. DeLuca, MD
 Timothy E. Sass, MD
 Harold S. Schell, MD
 Joseph R. Steeger, MD
 Anthony J. Vasselli, MD
 Mark J. Weinstein, MD
 Sophia C. Young, MD

Middlesex County

Ronnie Z. Bochner, MD
 Subash B. Duggirala, MD
 Issa E. Ephtimios, MD
 Jeffrey A. Weinstein, MD

Monmouth County

Luis B. Faelnar, MD
 Elliot Frank, MD
 Frank P. Gudicello, MD
 Stephen C. Keklak, MD
 Cynthia A. Kocsis, MD
 Paul F. Weber, MD

Morris County

Donald F. Cann, MD
 Alice C. Cardullo, MD
 Grant Parr, MD
 Michael A. Schalet, DO
 Millard D. Strutin, MD

Ocean County

David R. Grossman, MD
 Pandurang R. Miskin, MD
 Rex A. Zapanta, MD

Union County

Vilma Colon, MD
 Kathleen A. Heffernan, MD
 Jeffrey D. LeBenger, MD

Michael G. Mercado, MD
 Robert A. Panza, MD
 Paul M. Starker, MD

PLACEMENT FILE

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY

B.E. Shapiro, MD, 4144 Buttercup Ln., Plymouth Meeting, PA 19462. Temple 1985. Board eligible. Available.

Kishorkumar S. Vekaria, MD, 4805 Oxen Ct., Tampa, FL 33624. Baroda (India) 1982 and South Florida 1989. Board eligible. Group, partnership, solo. Available January 1990.

Ricky Zegelstein, MD, 4600 Ninth Ave., Brooklyn, NY 11220. Sackler 1984. Board eligible. Group or partnership. Available.

FAMILY PRACTICE

Leonid Belopolsky, MD, 955 Chanticleer Dr., Cherry Hill, NJ 08003. Moscow 1961. Board certified (ANES). Also, internal medicine. Available.

INTERNAL MEDICINE

Michael G. Donnelly, MD, 10 Overlook Rd., Apt. 4H, Summit, NJ 07901. Medical College of Pennsylvania 1987. Board eligible. Group or partnership. Available.

Charles Neal Jeck, DO, 9273-A Jamison Ave., Philadelphia, PA 19115. Philadelphia Osteopathic 1985. Board eligible. Group. Available.

Leonid Belopolsky, MD, 955 Chanticleer Dr., Cherry Hill, NJ 08003. Moscow 1961. Board certified (ANES). Also, family medicine. Available.

ORTHOPEDICS

D.C. Brown, MD, 2319 Sayre Dr., Princeton, NJ 08540. Available.

Carl Paul Kessler, MD, 5517 Ramillite Rd., Las Vegas, NV 89120. Jefferson 1961. Board eligible. Group, partnership, multispecialty, industrial, state.

THE PHILADELPHIA HEART INSTITUTE

Presbyterian Medical Center

CARDIOLOGY UPDATE



designed for the Physician and provides an intensive survey of the
current status of Clinical Cardiology

WEDNESDAY

OCTOBER 4, 1989

3:00 to 5:00 PM

REDUCTION OF MYOCARDIAL ISCHEMIA AND MYOCARDIAL INJURY

MODERATOR: BERNARD L. SEGAL, M.D.

- 3:00-3:30 The problem of restenosis after coronary angioplasty: mechanism, detection,
management and prevention *David O. Williams, M.D.*
- 3:30-4:00 Cardiac manifestations in patients with endocrine disorders: diagnosis and
management *Anthony Jennings, M.D.*
- 4:00-5:00 Case presentations—Angioplasty by balloon, laser, and other
procedures. Thyrocardiac disease *Marius Sharon, M.D.*
Panel discussion *Michael S. Feldman, M.D., J. David Ogilby, M.D.*
William J. Untereker, M.D.

- No Registration Fee
- Reception following session
- CME Credits*
- Call for Reservation 215-662-8627

* * *

**Scheie Eye Institute Auditorium
Presbyterian Medical Center
39th and Market Streets
Philadelphia, Pennsylvania**

Parking Available (at discount rate.)

* * *

*The University of Pennsylvania School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing education for physicians. The University of Pennsylvania School of Medicine designates this continuing medical activity for 2 credit hours per session in Category I of the Physician's Recognition Award of the AMA.

CONTINUING EDUCATION

RADIOLOGY

October

- Advances in Cardiovascular Diagnosis and Treatment**
6-9 P.M.—Stony Hill Inn, Hackensack
(*Eastern Heart Institute*)
- Cardiopulmonary Continuing Medical Education Semi-Annual Program**
4-9 P.M.—Center for Health Affairs, Princeton
(*Breathline, Inc.*)
- Heart Valve Reconstruction**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(*South Jersey Hospital System*)

- Hospital System, Bridgeton
(*South Jersey Hospital System*)
- 11 **Plasma Lipoproteins, Receptors, and Cholesterol Control**
1:30-5:30 P.M.—Drew University, Madison
(*Drew University and CIBA-GEIGY*)
- 11 **Current Topics in Medical Mycology and Parasitology**
8:30 A.M.-5 P.M.—Hyatt Regency, New Brunswick
(*Theobald Smith Society and AMNJ*)
- 11 **Individual Private Wells**
8:30 A.M.—Rutgers Labor Education Center, New Brunswick
(*NJ Clean Water Council*)

1:30-8 P.M.—Short Hills Hilton, Short Hills
(*AMNJ*)

- 18 **Drugs and Interpretation of Lab Studies**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(*AMNJ*)
- 18 **Computers in Medicine**
2-3 P.M.—John E. Runnells Hospital of Union County, Berkeley Heights
(*AMNJ*)
- 19 **Prevention of Lower Extremity Amputations**
2-3 P.M.—Woodbridge Developmental Center, Woodbridge
(*AMNJ*)

INFECTIOUS DISEASE

October

- Counseling and Testing for HIV Infection**
4-5 P.M.—South Amboy Memorial Hospital, South Amboy
(*AMNJ and NJDOH*)
- Susceptibility to Antimicrobial Agents**
11 A.M.-12 Noon—West Hudson Hospital, Kearny
(*West Hudson Hospital*)

- 12 **Nephropathy**
11 A.M.-12 Noon—St. Joseph's Hospital and Medical Center, Paterson
(*AMNJ*)
- 13 **Alzheimer's Disease**
9-11 A.M.—New Lisbon Developmental Center, New Lisbon
(*AMNJ*)
- 13-14 **1989 Eastern Section Meeting of the American Thoracic Society**
8:30 A.M.-6 P.M.—Claridge Hotel and Casino, Atlantic City
(*American Thoracic Society*)

- 20 **Calcium Channel Blockers and the Elderly**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(*South Jersey Hospital System*)
- 20 **Clinical Application and Future of Somatostatin Analogue**
8:30-10 A.M.—United Hospitals Medical Center, Newark
(*United Hospitals Medical Center*)

GERIATRICS

October

- Functional Assessment of the Elderly**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*AMNJ*)
- Retinopathy**
1-2 P.M.—V.A. Medical Center, Lyons
(*AMNJ*)
- Medical Lecture Series**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(*Christ Hospital*)
- Advances in Epilepsy**
All day—Robert Wood Johnson Medical School, New Brunswick
(*UMDNJ*)
- Thrombolytic Therapy**
12 Noon-1 P.M.—South Jersey

- 14 **Office Management of Diabetes**
8:30 A.M.-12:30 P.M.—Steven's Institute, Hoboken
(*AMNJ*)
- 15 **Techniques for Measuring the Value of a Medical Practice**
1:30-4:30 P.M.—MSNJ Headquarters, Lawrenceville
(*AMNJ and MSNJ*)
- 17 **Lyme Disease**
1:30-2:30 P.M.—Hunterdon Medical Center, Flemington
(*AMNJ*)
- 18 **Sports Medicine '89**
8:15 A.M.-1:00 P.M.—MSNJ Headquarters, Lawrenceville
(*MSNJ and AMNJ*)
- 18 **Clinical Management of Infection: Cost Containment**

- 21 **Morbidity and Mortality**
- 28 **Conference**
8:30-10 A.M.—New Jersey Medical School, Newark
(*UMDNJ*)
- 24 **Outpatient Management of Minor and Moderate Thermal Injuries**
8:30 A.M.-3:15 P.M.—United Hospitals Center, Newark
(*National Burn Victim Foundation*)
- 26 **Visiting Professor Program**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(*Saint Barnabas Medical Center*)
- 27 **Infections in the Geriatric Population**
10-11:30 A.M.—Marlboro Psychiatric Hospital, Marlboro
(*AMNJ*)
- 27 **New Developments in Osteoporotic Disorders**

The Academy of Medicine of New Jersey

presents

A MAJOR SYMPOSIUM

**BACTERIAL RESISTANCE
DEVELOPMENTS—LOOKING
AHEAD TO THE 90'S**

on

WEDNESDAY, OCTOBER 18, 1989

12:30 P.M.-9:00 P.M.

at

**THE SHERATON TARA,
PARSIPPANY, NEW JERSEY**

LEON SMITH, M.D.

Conference Chair

Director of Medicine

Chief of Infectious Disease

St. Michael's Medical Center, Newark

Professor of Medicine

UMDNJ—New Jersey Medical School

Past President, AMNJ

For further information on Registration, Faculty & Fees,
Please Contact:

The Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, New Jersey 08648
(609) 896-1717

*Grateful Acknowledgement is extended to
Lederle Laboratories
for their support of this Symposium.*

**NEW JERSEY
MEDICINE**

OPPORTUNITIES

CME

Pages 681,

726-731

**ADVANCES IN CARDIOVASCULAR
DIAGNOSIS AND TREATMENT**



Amarkanth R. Saxena, M.D.
Director, Eastern Heart Institute

Daniel P. Conroy, M.D.
Chief of Cardiology
Eastern Heart Institute

Oscar R. Baeza, M.D.
Chief of Cardiac Surgery
Eastern Heart Institute

Sanjeev Saksena, M.D.
Clinical Associate
Professor of
Medicine, University of
Medicine and Dentistry of
New Jersey; Chief of
Arrhythmia and
Pacemaker Service,
Eastern Heart Institute

**Continuing Medical
Education Credits**

*This program will meet the
criteria for 1.5 credits in
Category 1 for the American
Medical Association.*

Registration:

Advance registration is requested.
Please call 1-800-432-7834

Wednesday, September 20, 1989

Perona Farms Restaurant

Andover, NJ

Wednesday, October 4, 1989

Lon's Restaurant

East Rutherford, NJ

Presented By



**The
Eastern
Heart
Institute**

THE GENERAL HOSPITAL CENTER
at Passaic

350 Boulevard ■ Passaic, New Jersey 07055

8:30-10 A.M.—United Hospitals Medical Center, Newark
(*United Hospitals Medical Center*)

New Physician Program
All day—MSNJ, Two Princess Road, Lawrenceville
(*Medical Inter-Insurance Exchange of New Jersey*)

November

Medical Lecture Series
10:30-11:30 A.M.—Christ Hospital, Jersey City
(*Christ Hospital*)

Idiopathic Thrombocytopenia Purpura

11 A.M.-12 Noon—West Hudson Hospital, Kearny
(*West Hudson Hospital*)

New Concepts in the Prevention of Nonsteroidal Anti-Inflammatory Drug-Induced Ulcers

11 A.M.-12 Noon—West Hudson Hospital, Kearny
(*West Hudson Hospital*)

Morbidity and Mortality Conference

8:30-10 A.M.—New Jersey Medical School, Newark
(*UMDNJ*)

OBSTETRICS AND GYNECOLOGY

October

Semi-Annual Meeting

8 A.M.-5 P.M.—Sheraton Poste, Cherry Hill
(*NJ Obstetrical and Gynecological Society*)

Ultrasound Measurements

7:30-9:30 P.M.—Overlook Hospital, Summit
(*NJ Institute of Ultrasound in Medicine*)

November

Long-Term Consequences of Estrogen Deprivation

8:30-10 A.M.—United Hospitals Medical Center, Newark
(*United Hospitals Medical Center*)

ONCOLOGY

October

Psychological Aspects of Cancer
7-9 P.M.—The Still Rest, Tranquility
(*Hackettstown Community Hospital*)

Tumor Board Meeting

11 A.M.-12 Noon—In-house Hospital Annex, Sussex
(*Wallkill Valley Hospital Center*)

26 Tumor Board Conference

12 Noon-1 P.M.—Newcomb Medical Center, Vineland
(*Newcomb Medical Center*)

26 Dinner Meeting

6 P.M.—The Manor, West Orange
(*AMNJ*)

November

10 Tumor Board Conference

12 Noon-1 P.M.—Wallkill Valley Hospital Center, Sussex
(*Wallkill Valley Hospital Center*)

ORTHOPEDICS

October

27- Annual Meeting

28 Somerset Marriott Hotel, Somerville
(*AMNJ and NJ Orthopaedic Society*)

PEDIATRICS

October

5 Pediatric Grand Rounds

12 8:30-9:30 A.M.—Robert Wood Johnson Medical School, MEB,
26 102, New Brunswick
(*UMDNJ*)

11 The Dysmorphic Child

9 A.M.-3:30 P.M.—Children's Specialized Hospital, Mountainside
(*Children's Specialized Hospital*)

19 Pediatric Pulmonary Seminar, 1989

8:50 A.M.-4 P.M.—Quality Inn, North Brunswick
(*New Jersey Thoracic Society*)

24 Predictive Factors in Infant Intelligence

12 Noon-1 P.M.—Newark Beth Israel Medical Center, Newark
(*Newark Beth Israel Medical Center*)

26 Update in Aspects of Pediatrics

Marriott Hotel, Saddle Brook
(*Northern NJ Pediatric Society*)

November

2 Pediatric Grand Rounds

9 8:30-9:30 A.M.—Robert Wood Johnson Medical School, MEB,

30 102, New Brunswick

(*UMDNJ*)

30 Update in Aspects of Pediatrics

Marriott Hotel, Saddle Brook
(*Northern NJ Pediatric Society*)

PSYCHIATRY

October

2 Medical and Psychiatric Aspects of Drug and Alcohol Abuse

1-2 P.M.—Essex County Hospital Center, Cedar Grove
(*AMNJ*)

5 Urine Drug Testing

12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

12 Psychiatrists and the Treatment of Addictions

12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

19 Female Gamblers

12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

19 Psychoanalytic Perspective on Depression

8 P.M.—Hackensack Medical Center, Hackensack
(*NJ Psychoanalytic Society*)

25 Ethics of Clinical Psychiatry

All day—Carrier Foundation, Belle Mead
(*Carrier Foundation*)

26 Anxiety Syndromes with Cardiovascular Symptoms

11 A.M.-12 Noon—St. Joseph's Hospital and Medical Center, Paterson
(*St. Joseph's Hospital and Medical Center*)

27 Anxiety Disorders in Primary Care

12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(*South Jersey Hospital System*)

November

2 Electroconvulsive Therapy

SPECIAL ISSUE:

Continuing Medical Education

Send \$5 check to:

NEW JERSEY MEDICINE
Two Princess Road
Lawrenceville, NJ 08648

FINANCIAL STRATEGIES FOR THE 90'S

A Deluxe Seminar Exclusively for the Professional

HAWAII, NOVEMBER 28 TO DECEMBER 5, 1989

\$2098 Per Person,
Double Occupancy

- ★ Keeping More of What You Earn
- ★ The Valuation and Sale of A Practice
- ★ The Why and How of Estate and Retirement Planning Preserving Assets, Tax Credits and Gifts
- ★ Tax Shelters What the 1031 Tax Free Exchange Means To You and More
- ★ Make the Tax Laws Work For You
- ★ The Power of Tax Free Income

Package Includes:

Hawaii's Most Elegant Resort Hotels

- 3 Nights Kahala Hilton Hotel
- 4 Nights Mauna Kea Beach Hotel
- New York, Newark, Philadelphia, Hartford, Boston departures
- 4 Group Meetings—2 Dinners, 4 Breakfasts
- Tours, Transfers, Gratuities on Covered Meals and Activities, Taxes
- Seminar Registration Fee additional

Seminar Director:

EUGENE L. STOLER, JD, CPA, LLM

Member of the New York Bar

Adjunct Ass't. Professor of Taxation, LIU Graduate School of Business

Member, Distinguished Faculty Bank of the Foundation for Education, NY State Soc. of CPAs

New Decisions Editor, Journal of Taxation

Mr. Stoler is **NOT** associated with any securities, insurance or other financial instrument sales organization.

ABSOLUTELY NO SALES WILL BE SOLICITED!

Registration Will Be **STRICTLY** Limited For More Personal Interaction

For further information, contact:

CAPITAL SEMINARS, INC.

P.O. Box 224 • Demarest, NJ 07627 • (201) 768-4324

OFFICE COMPUTER SYMPOSIUM

FOR PHYSICIANS AND THEIR STAFF

Sponsored By

MEDICAL SOCIETY OF NEW JERSEY—YOUNG PHYSICIAN COMMITTEE

DONALD CINETTI, M.D.—COMMITTEE CHAIRMAN

JOSEPH CALDERONE, JR., M.D.—SYMPOSIUM CHAIRMAN

WILLIAM CONSTAD, M.D.—SYMPOSIUM CO-CHAIRMAN

PRODUCT PRESENTATIONS with HANDS-ON COMPARISONS & CLASSROOM SEMINARS with TOPICS INCLUDING:

- What computers can do for the physician's office
- How to get more out of your present computer
- Current trends in billing practice
- Converting from manual to automated billing
- Electronic claims
- Computer selection process for the first-time buyer
- Replacing your present system

DATE: SATURDAY, NOVEMBER 4, 1989

PLACE: MSNJ HEADQUARTERS
2 PRINCESS ROAD
LAWRENCEVILLE, NJ 08648

TIME: 9:00 A.M.—4:00 P.M.

REGISTRATION FEE: \$30—MSNJ MEMBER
(INCLUDES LUNCH) \$60—NON-MEMBER

For further information contact Ron Rouse at (609) 896-1766

12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

Psychotherapy with Medically Ill Patients

12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

The Many Faces of Depression and Anxiety

All day—Carrier Foundation, Belle Mead
(Carrier Foundation)

Horticultural Therapy: A Rose Among Treatments

12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

Transference and Countertransference Reactions in the Management of Ambulatory Schizophrenia

12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

12 Noon-1 P.M.—St. Lawrence Rehabilitation Center, Lawrenceville
(St. Lawrence Rehabilitation Center)

November

- 10 **Update in Pulmonology**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(South Jersey Hospital System)

RADIOLOGY

October

- 18 **Nuclear Medicine**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)
- 19 **1989 Scientific Meeting**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of New Jersey-Diagnostic Section, AMNJ)

November

- 16 **1989 Scientific Meeting**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of

New Jersey-Diagnostic Section, AMNJ)

SURGERY AND ITS SPECIALTIES

October

- 3 **Weekly Vascular Case**
10 **Conference**
17 7:30-8:30 A.M.—Robert Wood
24 Johnson Medical School, MEB,
31 108B, New Brunswick
(UMDNJ)
- 7 **Surgical Treatment of**
14 **Cardiothoracic Disease**
21 10-11:30 A.M.—New Jersey
28 Medical School, MSB, 506B, Newark
(UMDNJ)
- 25 **Journal Club, Section of Cardiothoracic Surgery**
6:30-9:30 P.M.—2 Mountain Ridge Drive, Livingston
(UMDNJ)

November

- 3 **Peripheral Vascular Disease**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(South Jersey Hospital System)
- 7 **Weekly Vascular Case**
14 **Conference**
21 7:30-8:30 A.M.—Robert Wood
28 Johnson Medical School, MEB, 108B, New Brunswick
(UMDNJ)
- 4 **Surgical Treatment of**
11 **Cardiothoracic Disease**
18 10-11:30 A.M.—New Jersey
25 Medical School, Newark
(UMDNJ)
- 9 **Reconstructive Microsurgery**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(AMNJ)
- 29 **Journal Club, Section of Cardiothoracic Surgery**
6:30-9:30 P.M.—2 Mountain Ridge Drive, Livingston
(UMDNJ)

UROLOGY

October

- 6 **Urology Grand Rounds**
13 New Jersey Medical School,
20 MSB, C600, Newark
27 (UMDNJ)
- 11 **Urinary Tract Infections**
1:30-2:30 P.M.—Vineland Developmental Center, Vineland
(AMNJ)

November

- 3 **Urology Grand Rounds**
10 New Jersey Medical School,
17 MSB, C600, Newark
24 (UMDNJ)

ARE YOU MOVING?

so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

category: (Please check one)

Member, MSNJ

☐ Subscriber, NJ Medicine

Other _____

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____



WHEN IT COMES TO YOUR FINANCIAL HEALTH, YOU DESERVE A SPECIALIST.

There's never enough time in the day, or night, to manage a busy health care practice—and its finances. That's why Midlantic National Bank/North created the Medical/Dental Banking Group.

Whether you're starting a new practice, purchasing an established one, or buying into a group practice, see a Medical/Dental Specialist at Midlantic. We're professionals with an in-depth knowledge of your unique situation. We'll work with you on an individual basis in securing a loan for new equipment, leasehold improvements, or working capital. And, tailor a graduated repayment schedule based on your needs.

If you're just starting out, ask about Midlantic "Healthy Start" Cash Flow Management Program, a conveniently scheduled series of one-on-one consultations regarding financial management for optimization.

For more information, and to receive our brochure "A Complete Financial Services Program for Health Care Professionals," speak with Patrick Robin, Vice President and Group Manager, at 1-800-881-5191 or (201) 881-5191.

Talk with a Midlantic Medical/Dental Specialist. We think you'll agree that in the long run prevention is worth a pound of cure.

Member FDIC
Equal Opportunity Lender

MIDLANTIC
Midlantic National Bank
The Hungry Bank

IN MEMORIAM

William H. Behringer. Word has been received of the untimely death of William Hayman Behringer, MD. Born in 1942 in Allentown, Pennsylvania, Dr. Behringer received his medical degree from Temple University Medical School, Pennsylvania, in 1969. Dr. Behringer practiced otolaryngology in Princeton and Hightstown, and was affiliated with The Medical Center at Princeton. In addition, he was an assistant professor at Thomas Jefferson University, Philadelphia, and at MDNJ-Robert Wood Johnson Medical School, New Brunswick. A member of our Mercer County component, Dr. Behringer was a member of the American Medical Association and of the New Jersey Academy of Ophthalmology and Otolaryngology. In addition, he is a fellow of the American College of Surgeons and of the American Academy of Facial Plastic and Reconstructive Surgery, and a diplomate in his specialty.

Otto Brandman. Retired metabolic consultant and specialist in diabetes, Otto Brandman, MD, died at the age of 88 on April 1989. Dr. Brandman, a graduate of the Jan Casimir University Medical School, Poland, maintained a private practice in Maplewood from 1941 to 1985. During his lengthy career, Dr. Brandman was affiliated with Saint Michael's Medical Center, Newark, and Newark City Hospital. In addition, he was an associate professor of medicine at MDNJ-New Jersey Medical School. Dr. Brandman served as president of the New Jersey State

Diabetic Association and was one of the founders of the graduate medical school of Seton Hall College of Medicine and Dentistry. A member of our Essex County component and the AMA, Dr. Brandman was a member of the American Diabetes Association and of the American Heart Association. Annually, Dr. Brandman was honored by the American Diabetes Association by the presentation of the Otto Brandman Awards.

Rudolfo B. Caceres. A member of our Passaic County component, Rudolfo Caceres, MD, died on May 22, 1989, at the age of 63. Born in Peru, Dr. Caceres emigrated to the United States in 1953. He earned his medical degree from San Marcos University, Lima, in 1952. A family physician with a practice in Little Falls, Dr. Caceres was affiliated with St. Joseph's Hospital and Medical Center, Paterson. He was a member of the American Medical Association.

William Cassio. A general practitioner, William L. Cassio, MD, died in December 1988. Born in 1912 in Texas, Dr. Cassio was graduated from Meharry Medical College, India, in 1941. Dr. Cassio received his license to practice in New Jersey in 1945; he was a member of our Essex County component.

Anthony Chiofalo. New Jersey air surgeon, Anthony Chiofalo, MD, died in May 1989, at the age of 63. Dr. Chiofalo was state air surgeon at the headquarters of the New Jersey Air National Guard at

McGuire Air Force Base. Born in 1926, Dr. Chiofalo received his medical degree from Palermo Medical School, Italy, in 1951 and was awarded his New Jersey license in 1957. He also served as a physician for the New Jersey State Police, the Hammonton School District, and the Hammonton Police Department. He was on the Board of Directors of the Kessler Memorial Hospital, Hammonton. Dr. Chiofalo was a member of our Atlantic County component.

Raymond L. Cunneff. Word has just been received of the death of Raymond Leo Cunneff, Jr., MD. Dr. Cunneff received his medical degree from Jefferson Medical College, Pennsylvania, in 1952 and his New Jersey license in 1957. A member of our Monmouth County component, of the American Medical Association, and of the American Academy of Orthopaedic Surgeons, Dr. Cunneff was affiliated with Monmouth Medical Center, Long Branch, and Riverview Hospital, Red Bank; he was a diplomate of the American Board of Orthopaedic Surgery. He served as a captain in the U.S. Air Force Medical Corps, from 1954 to 1956.

Jose P. daSilva. Psychiatrist Jose Palma daSilva, MD, of Scotch Plains, died on May 12, 1989, at the age of 65. A Portugal native, Dr. daSilva received his medical degree from the University of Lisbon, Portugal, in 1947. A staff member of Rahway Hospital, Dr. daSilva ran private practices in Newark and Westfield beginning in 1957, and in Rahway begin-

ning in 1984. He was a member of the American Psychiatric Association, of the Association of Military Surgeons, of our Essex County component, and of the AMA. Dr. daSilva served in the United States Navy medical corps in active duty from 1955 to 1957, and in the reserves until 1967.

Alfred C. Elmer. An obstetrician-gynecologist and a member of our Essex County component, Alfred Cornwell Elmer, MD, died on May 21, 1989. Born in 1928, Dr. Elmer was graduated from Jefferson Medical College, Pennsylvania, in 1955. Dr. Elmer had a private practice in Bridgeton and then West Orange; he was affiliated with Saint Barnabas Medical Center, Livingston, and Margaret Hague Hospital, Jersey City. A member of the American Medical Association. Dr. Elmer served in the United States Air Force from 1956 to 1958 as a captain.

Alvin L. Galitzin. A member of our Bergen County component, Alvin L. Galitzin, MD, of Demarest, died on April 25, 1989. Dr. Galitzin was chief of psychiatry at Holy Name Hospital, Teaneck, and also was on staff at Hackensack Medical Center and Englewood Hospital. Born in 1927, Dr. Galitzin earned his medical degree from the University of Bologna, Italy, in 1961.

John H. Hermann, Jr. Word has been received of the death of John H. Hermann, Jr, MD, 72, on April 27, 1989. Born in Orange, Dr. Hermann received his medical degree from McGill University, Canada, in 1942; he then served in the United States Army from 1943 to 1946 as a major. Dr. Hermann maintained a private practice in general medicine in Orange for 36 years, retiring in 1983; during his career, he was affiliated with St. Mary's Hospital, Orange. Dr. Hermann was a member of our Essex County component, of the

American Medical Association, and of the Academy of Medicine of New Jersey.

William D. Melosh. Retired early this year from active practice, obstetrician-gynecologist William Donald Melosh, MD, died on May 9, 1989, at the age of 65. Dr. Melosh received his medical degree from New York Medical College in 1948, and, following a move from Salt Lake City, Utah, 32 years ago, he maintained a private practice in Montclair from 1957 to 1981. Affiliated with The Mountainside Hospital, Montclair, Dr. Melosh was a diplomate in obstetrics and gynecology and a fellow of the American College of Obstetricians and Gynecologists. He was a member of our Essex County component, and of the AMA.

Albert F. Misko. Word has been received of the death of Albert Francis Misko, MD, a member of our Somerset County component. Born in 1912, Dr. Misko earned his medical degree at New York University Medical School in 1939, and received his license to practice in New Jersey in 1943. A general practitioner, Dr. Misko was affiliated with Muhlenberg Hospital, Plainfield, and Somerset Hospital, Somerville. Dr. Misko was a member of the American Medical Association.

Michael J. O'Kane. East Brunswick family physician Michael Joseph O'Kane, MD, died on May 7, 1989. A 1928 native of Irvinestown, Ireland, Dr. O'Kane received his medical degree from Queen's University, Belfast, Ireland. After emigrating to the United States and moving to East Brunswick, Dr. O'Kane started a private practice and served as township physician. Affiliated with St. Peter's Medical Center, New Brunswick, Dr. O'Kane was a member of the General Medical Council, of the British Medical As-

sociation, and of our Middle County component. He was a U.S. Army lieutenant and field surgeon in the Korean War.

Raymond L. Russomanno. general practitioner in Newark the past 59 years, Raymond Lawrence Russomanno, MD, died May 6, 1989. Dr. Russomanno earned his medical degree from Loyola University School of Medicine, Chicago, in 1930. Russomanno served on the staffs of Saint Barnabas Medical Center, Livingston; St. Vincent's Hospital, Montclair; Clara Maass Medical Center, Belleville; and Montclair Community Hospital. A member of our Essex County component and of the American Medical Association, Dr. Russomanno was a fellow of the American College of Gastroenterology and a fellow of the American College of Endocrinology.

George P. Schwab. George Peter Schwab, MD, a retired member of our Hudson County component, MD, died on April 29, 1989, at the age of 77. Dr. Schwab was an attending physician in urology at St. Mary Hospital, Hoboken, when he retired in 1984; he served as president of the hospital's medical staff in 1974. During World War II, Dr. Schwab served in the United States Army Medical Corps. Dr. Schwab was born in Union City and received his medical degree from New York Medical College in 1937, and his New Jersey license in 1938.

Mario S. Sipin. Word has been received of the death of Mario Sison Sipin, MD, on December 1, 1988. A general surgeon, Dr. Sipin was a member of our Cumberland County component. Dr. Sipin received his medical degree in 1961 from the University of Santo Tomas, Philippines, and received his New Jersey license in 1964. Dr. Sipin was an attending at Millersville Hospital.

EDITORIAL CRITERIA

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. All material published is copyrighted by MSNJ.

Content. The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; literature update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Editors' Notebook section contains organizational, informational, and administrative news from MSNJ and from the community. Letters to the editor and book reviews are welcome and may be published as space permits. The principal aim in the preparation of a contribution should be relevant to diagnosis and treatment and to education of patients and health professionals. Preference will be given to professional authors in New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made to an audience in New Jersey.

Assignment of Copyright. In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or separate statement accompany-

ing material offered to *NEW JERSEY MEDICINE* must contain the following language and must be signed by all authors.

"In consideration of *NEW JERSEY MEDICINE* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *NEW JERSEY MEDICINE*.

Specifications. Submit two manuscripts that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods should be identified.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

The author should submit a 30-word abstract.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission must be submitted.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

References should not exceed 35 citations except in review articles, and should be cited consecutively by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in numerical order. The style of *NEW JERSEY MEDICINE* is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

Publication Policy. Receipt of each manuscript will be acknowledged; the paper will be referred to the Editorial Board. The final decision is reserved for the editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. Galley proofs will be submitted to the author for correction.

Reprint Orders. Reprints may be ordered after the author is notified that the article has been selected for a specific issue. A check for the cost of reprints must accompany that order.

Communications. All communications should be sent to the editor, *NEW JERSEY MEDICINE*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

Teaneck

\$259,000

PROFESSIONAL—DOCTOR'S OFFICE

This low-maintenance home on highly visible corner property with convenient side street parking offers good exposure and is convenient to local and N.Y.C. transportation. First floor offers separate entry, waiting room, offices, examining room, powder room and full kitchen which could serve as lab area. Second floor apartment has newer kitchen, living room, 2 bedrooms, and 2 full baths. Full basement, attached garage, and stone, brick and shake exterior make this property practical and attractive.

****Estate Sale—Priced below appraised value****



Schlott Realtors
Saddle River, NJ
201-327-5600

Route 35

Hazlet, N.J.

BETHANY COMMONS OFFICE CONDOS FOR SALE OR LEASE

950 sq. ft. to 10,400 sq. ft. campus setting. Phase 1 pricing available.

ERIC BRAM & COMPANY

Exclusive Broker

28 Kennedy Boulevard
East Brunswick, NJ 08816
(201) 545-1414

FOR SALE

Home-Office-Practice-Equipment

Prestigious Roseland, Essex County, Eagle Rock Avenue. 20 year old, custom designed, built, corner property, private parking.

4 bedrooms, 3½ baths, Living room with marble fireplace. Family room has Tennessee marble working fireplace. Formal dining room, modern kitchen with pantry, laundry room. Sun room air conditioned, heated. Attractive dinette has built-in cabinets, desk. Central air, central vac, sprinkler system. Complete 2 bedroom basement apartment; kitchen, laundry, walk-in closets. Separate entrance. Excellent for mother-daughter. Building front, Tennessee marble stone. Professionally landscaped and maintained. Six-room office, attractive private entrance. Ample closet space. 20 minutes to New York, 8 minutes to major hospitals. 30 year practice and almost new equipment will be negotiable.

Asking \$599,000 ... Principals only ...
Call 201-226-4040

PRACTICE FOR SALE

Middlesex County gynecologist offers for sale his successful growing practice, professional offices, and family residence.

The practice includes examination equipment, modern office furnishings, active list of patients, and will stay to transition.

The professional offices include an entry vestibule, patient waiting room, nurses station, consultation office, two examination rooms and a bathroom. Ask for Elaine Patania for complete confidentiality.



H & G REALTY

84 Stelton Road
P.O. Box 8493
Piscataway, N.J. 08854

Office: (201) 968-4900

Eve: (201) 752-8

MEDICAL OFFICE FOR RENT MORRIS COUNTY, N.J.

- ON SITE PARKING
- MINUTES TO MORRISTOWN MEMORIAL, ST. CLAIRE'S HOSPITAL, DOVER GENERAL HOSPITAL

**CENTRAL MORRIS MEDICAL-
DENTAL ARTS PLAZA**
2839 ROUTE 10
MORRIS PLAINS, NEW JERSEY 07950
201-539-5700

OFFICE SPACE

Medical office space (800 square feet) in War Township on Mountain Boulevard available on part-time basis from as little as 2 hours per week. Rent is charged hourly. Call (201) 754-7711.

MEDICAL OFFICE AVAILABLE IN WESTVILLE, NEW JERSEY

- Physician moving from area after 11 years
- Office ready for new physician:
Records, furniture, great opportunity for new physician with modest means

CALL 609-456-5878 FOR INFORMATION

DOCTOR'S OFFICE

Doctor's office with seven Examination Rooms, Reception Room, Two Bathrooms, and Waiting Hall. In neighborhood where local practitioner retiring. Lease \$895.00 per month. Possible option to Buy.

Superior Real Estate Services
7020 Rt. 130
North Delran, NJ 08075
609-764-8606





MSNJ NEWSLETTER

MEASLES EMERGENCY

Effective immediately, the Measles Emergency Guidelines, issued on March 1, 1989, for Hudson, Bergen, Essex, Passaic, and Union counties no longer are in effect. Between mid-January and June 30, 1989, 480 suspect measles cases were reported from the northern part of the state to the Communicable Disease Operations Program (CDOP). Of these, 103 cases were reported to have onset dates in May, but only 44 cases were reported for the entire month of June.

An analysis of the outbreak is not yet possible because completed investigations on all of the cases are not available. However, information on the initial 222 cases indicates 190 cases (85 percent) were reported from Hudson, Passaic, Union, Bergen, and Essex counties. Fifty percent or 111 of these cases were reported from Hudson County. Sixty-two municipalities reported at least 1 case; however, Jersey City accounted for 58 cases (26 percent), Union City accounted for 20 cases (9 percent), and Newark accounted for 10 cases (5 percent). The remainder had 8 or fewer cases reported. Ninety-six (96/222) cases (43 percent) occurred in children less than 5 years of age with 53/222 cases or 24 percent in children less than 15 months of age. One hundred six cases (48 percent) occurred in individuals between 5 and 19 years of age.

Because recent measles activity appears to be decreasing, the following now are recommended: 1. The routine age for measles immunization should return to 15 months of age in all counties except in Hudson County where children should be immunized at 12 months of age; that is, on or after their first birthday. Children immunized on or after their first birthday do not need to be reimmunized at 15 months. 2. If suspect measles cases continue to be reported to local health departments, they should be investigated immediately and reported to the State Department of Health. 3. Serum specimens on suspect cases should still be obtained and sent to the state laboratory for confirmation of the diagnosis.

SOCIETY PROTESTS CALLER I.D.

The Medical Society of New Jersey has filed a protest with the Board of Public Utilities concerning the Caller I.D. Program offered by New Jersey Bell. If you are upset by this program and the invasion of your privacy, please forward a letter indicating this information to Mr. Vincent A. Maressa, General Counsel, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

MARKETING OF PRESCRIPTION DRUGS

The AMA expressed its disapproval of product-specific marketing of prescription drugs, infant formula, and devices directly to the public. The Association stated that these products require prescriptions by a physician for safe utilization, to qualify for third-party support, or to assure the effective nurture and thriving of infants who are denied sufficient breast milk and are dependent in some part on infant formula. (Letter to Representative Tom Harkin; June 30, 1989.)

PHYSICIAN PAYMENT UNDER MEDICARE

The Association offered its views in opposition to expenditure targets under Medicare, and in support of a physician reimbursement system

based on a resource-based relative value scale. The AMA also supports an aggressive program for the development and use of practice parameters and outcome assessment research. (Remarks of James H. Semon, MD, to the Senate Finance Committee; July 19, 1989).

PHYSICIAN REIMBURSEMENT

The AMA continued to oppose expenditure targets (ETs) under Medicare. The AMA pointed out that charges that ETs were necessary bring down 17 percent yearly increases in Medicare Part B costs were wrong and that in the last two years rates of increase had declined substantially. The AMA also denied allegations of "vast" amounts of unnecessary services. (Letter to Lloyd Bentsen, Senate Finance Committee; July 25, 1989.)

DEPARTMENT OF HEALTH ORDER

In accordance with P.L. 1989, Chapter 51, there is hereby established a Division of Alcoholism and Drug Abuse. The new Division merges the Divisions of Narcotics and Drug Abuse Control and Alcoholism. The new Division will continue to have responsibilities for a wide range of prevention, education, training, and treatment services. Additional activities will start due to recently passed state legislation. This legislation instituted a Governor's Council on Alcoholism and Drug Abuse and greater responsibility by counties and municipalities in alcoholism and substance abuse services. Richard Russo, MSPH, will be acting assistant commissioner for the new Division. He will be working with Division of Alcoholism and Division of Narcotic and Drug Abuse staff to effect the integration of programs and staff into the new Division over the next six weeks. The Division of Alcoholism and Drug Abuse will report to Deputy Commissioner Christine M. Grant, JD, MBA.

EXPENDITURE TARGETS

The following letter is from Congressman Matthew J. Rinaldo:

I share your concerns that the expenditure target proposal could cause many physicians to reconsider whether they will take on new Medicare patients. It will interest you to know that my staff has been working with the AMA on this particular issue and I have written to the President reinforcing the physicians' objections. Specifically, I pointed out that the deficit reduction targets for FY 1990 can be met without imposing expenditure targets. Furthermore, I am convinced that there is not sufficient data to move forward with the initiative at this time.

As you may know, the Ways and Means Committee recently passed their budget reconciliation package which included a provision for expenditure targets. The Energy and Commerce Committee, of which I am a member, did not include this provision when it passed its physician payment reform package this week. I do not believe such a controversial and untested proposal should be attached to a comprehensive legislative package. It should be considered on its own merits. You may rest assured that I will do everything possible to delay implementation until further study may be completed and to search for other cost-containment strategies.

SMOKING ABOARD AIRCRAFT

The Medical Society of New Jersey urges you to vote to extend the airline smoking ban, due to expire April 1990. There have been no scientific findings, no enforcement problems, nor any practical structural alternatives that would justify reversing the smoking ban by letting it expire. Over the last several years, the adverse health consequences to nonsmokers exposed to secondhand smoke have been well documented by the Surgeon General. In addition, a specific recommendation to ban smoking aboard aircraft appeared in the National Academy of Sciences' report, *The Airliner Cabin Environment*. This study, which had been

ordered by Congress, concluded that environmental tobacco smoke is a hazardous substance in the aircraft cabin environment.

The Society advocates a ban on smoking aboard all flights regardless of duration. We recognize that because of their addiction to nicotine, smokers may be uncomfortable and inconvenienced with abstaining from smoking aboard flights of very long duration. However, there are a number of activities which individuals are foreclosed from doing aboard aircraft because of safety and other considerations. It is not unreasonable to put smoking in that category.

In conclusion, the elimination of smoking aboard aircraft is a measure that improves the health, well being, safety, and comfort of airline passengers and crew at no additional cost to the government or to the airlines. We ask that every New Jersey member of the House of Representatives vote to support the ban.

PROFESSIONAL LIABILITY ALERT

On June 5, 1989, the Indiana Department of Insurance obtained an injunction against the Medical Liability Purchasing Group Inc. of Indiana (MLPG). It has solicited health practitioners throughout the United States by mail to purchase malpractice insurance. The information used was not accurate and the company used "Carib," which is incorporated in Guam and is not an admitted insurer in any state. If you have any questions about this matter please contact Karen B. Neiswinger, Counsel, Indiana Department of Insurance, 317/232-5063.

MEDICARE PAYMENT DELAY PROPOSED

In an effort to still the controversy over the Catastrophic Illness Protection Act, the House Ways and Means Committee advanced another flawed proposal to the full House of Representatives. Medicare beneficiaries will be able to withdraw from both the catastrophic plan and the Part B program. To compensate for lost revenues, the House will consider raising Part B premiums, increasing the outpatient drug deductible, and delaying Medicare payments by an additional five days at the end of the fiscal year 1990. Whether the House will accept the proposal is uncertain.

STATE MEDICAID REFORM UNCERTAIN

A five-year, \$80 million program proposed by former Commissioner Drew Altman of the State Department of Human Services, has been put on hold. The program was aimed at raising Medicaid fees to physicians and decreasing the number of unnecessary emergency room visits by Medicaid patients. The Kean Administration has used the excuse of budget constraints to scuttle the program. While some physician fees were raised significantly last year, they still are well below market level. Another victim of the budget crunch is the fatally flawed Garden State Health Plan (Medicaid HMO). Its funding was deleted from the budget. What all of this means is not clear except that the Medicaid Program in New Jersey continues to flirt with a charge of "noncompliance" by the federal government. If the state administration continues to ignore this issue, some \$900 million of federal matching funds could be at risk. The Society's skepticism that Altman and the Governor would or could follow through unfortunately has been realized.

SBME LICENSING FEES

Over the years, the State Board of Medical Examiners gradually has increased the biennial licensing fee to its current rate of \$160. Many physicians have written to the Society complaining about the excessive rate they are paying. Without access to the internal budget of the State Board of Medical Examiners we have been unable to ascertain the appropriateness of the fee. It does, however, appear reasonable when compared to the fees charged other professions in our state.

Connecticut, one of our neighbors to the north, is another story. In recent feeding frenzy for new tax revenues, the Connecticut General Assembly raised the annual licensing fees charged to all professional Physicians were raised from \$160 to \$460.

Let's hope we avoid a "northeaster."

AFGHAN REFUGEE ASSISTANCE PROGRAM

The Afghan Refugee Assistance Program is a humanitarian project of the Freedom Foundation of New Jersey, Inc. Medical facilities in Afghanistan are almost nonexistent. The Afghan refugee population is the largest in the world (five million) with many of them bearing physical scars and missing limbs. New Jersey doctors and hospitals have been generously giving many hours of their services freely, in order for these war wounded refugees to be rehabilitated.

The Medical Society of New Jersey is pleased to recognize and commend the following doctors and hospitals that have participated in this worthwhile effort: St. Joseph's Hospital, Paterson; Meadowlands Medical Center, Secaucus; Kessler Hospital, Hammonton, Peter Lipron, MD; The Medical Center at Princeton, Princeton, Andrew C. Lipka, MD and Jeffrey L. Lipkowitz, MD; Holy Name Hospital, Teaneck, Richard D'Amico, MD; Roseland Medical Center, Bloomfield, Herbert L. Glatt, MD; and St. Claire's Hospital, Denville.

SCIENCE AND TECHNOLOGY

Albert R. Tama, MD, a member of our Camden County component and executive vice-president for medical affairs at Cooper Hospital, University Medical Center, has been appointed to the New Jersey Commission on Science and Technology for a five-year term. Commission chairman Dr. James F. Mathis noted, "We are very pleased that such a high caliber health care professional has joined our Commission. Dr. Tama's extensive experience as a physician, professor of medicine, and hospital administrator will enable him to make a valuable contribution to the development of all our programs, particularly in the field of biotechnology."

SUPPORT SERVICES

A program designed to help physicians cope with the constant exposure to contract proposals and fraud and abuse constraints upon physicians business activities will be held in Philadelphia, on October 14 and 15, 1989. This two-day seminar is being presented by Physician Support Services, Inc., and all MSNJ members will receive a 10 percent discount. For more information, contact Mr. Joseph Lucci, MSNJ, 609/896-1766.

SPORTS MEDICINE

"Sports Medicine '89" will be held on October 18, 1989, at the Medical Society of New Jersey headquarters. The program, sponsored by the Committee on Medical Aspects of Sports, will feature two symposiums: "Head and Neck Injuries in Sports," and "Anabolic Steroids." Registration opens at 8:15 A.M., and the program begins at 9 A.M. in Lawrenceville. For additional information, call MSNJ, 609/896-1766.

CLEARINGHOUSE SPEAKERS BUREAU

The Self-Help Clearinghouse from St. Clare's-Riverside Medical Center can provide speakers to give presentations and workshops. Talks can be specialized or general and tailored to the interests of the audience. They serve the entire state and usually talk to groups of 100 or more. Should any members want additional information, please contact Gwen Roe, education and outreach coordinator, 201/625-9565.

FINI

"The trouble with some people is that they are educated beyond their intelligence."



PROFESSIONAL LIABILITY

HOSPITAL RECORDS DEFEND PHYSICIANS

A complete, accurate, and objective record offers a solid foundation for defending physicians, hospitals, and nurses against allegations of negligence, improper treatment, or omissions in care. Poor medical records encourage plaintiffs' attorneys to pursue many malpractice cases that are medically defensible. Medical records do not treat patients. But in a malpractice action, the plaintiff-patient frequently bases his or her case on allegations contrary to the assertions of physicians and nurses. Although the "burden of proof" of negligence is the plaintiff's burden, an incomplete, inconsistent, or inaccurate medical chart benefits the plaintiff's case and jeopardizes the defense.

The hospital chart is an important aid to health professionals responsible for providing proper and adequate treatment. Physicians rely on notes by consultants, nurses, and others who cotreat patients. Serious injury to the patient is avoided when the chart is current and reflects the patient's progress, or lack of it, during hospitalization.

Four essential characteristics of a good hospital medical chart are: completeness, objectivity, consistency, and accuracy. The chart must be complete to protect the patient from injury during hospitalization. As the chart may be used in litigation for personal injury, worker's compensation, child custody, and employment disputes, as well as in malpractice actions, the chart's accuracy and objectivity can be of benefit to the patient in these nonmedical forums. The consistency and accuracy of the information recorded by physicians and nurses may be factors in determining whether a patient can obtain insurance, keep his job, qualify for a new job, or receive disability ratings. The completeness and accuracy of the medical record also may affect reimbursement for the hospital and physicians.

The medical chart which best protects the patient from injury, and enhances the defense of a malpractice claim, includes the following:

Admitting History. The admitting history objectively identifies the patient's complaints, including the duration of symptoms or illness. Allergies, previous reactions to medication, anesthetic agents, and past treatment and surgery are noted. If history is provided by someone other than the patient, the historian's identity should be charted. A distinction should be made between what the patient reports and what the physician determines in an examination. During the course of the hospitalization, some information recorded in the initial history might prove to be inaccurate. Significant changes, such as later reports of allergies, or the patient's revision or revocation of consent, should be documented in a dated, signed addendum and in the progress notes for the benefit of other physicians and nurses involved in the patient's care.

Physicians' Orders. Clear, concise orders facilitate communication between physicians and nurses. Specific orders prevent errors and avoid delays in compliance. Instead of an order such as "Check neuro signs," the physician should indicate how often neurological signs should be

checked and what specific findings should be reported immediately. Vague order such as "Call me if problems develop," may result in delay or unnecessary calls to the physician. Orders should state what type of problems require notice to the physician. Orders should include the date and time they were written.

Progress Notes. Physicians' progress notes should be meaningful and objective. Many physicians use the SOAP format for progress notes which prompts complete and consistent entries: S = subjective data, how the patient says he feels and what his complaints are; O = objective findings the physician observes or finds on examination; A = assessment of the objective findings and the patient's subjective complaints; P = plans for treatment now and in the future. Other charting formats are effective if they include sufficient information to assist others who will treat the patient and adequately document the patient's progress. A progress note that reports "No problems," does not adequately document examinations or discussions. A narrative progress note should make reference to relevant aspects of the patient's case. For example, postoperative notes might mention wound condition, drainage, the absence of signs of complications, or other pertinent negatives. Progress notes should include the time of the physician's visit.

Operative Reports and Discharge Summaries. Timely dictation of operative reports and discharge summaries protects the patient and physician. A report dictated long after a complication has occurred may be regarded as self-serving and inaccurate. Physicians on call for the surgeon and physicians expected to follow a patient after hospitalization are better able to assess the case when operative reports and discharge summaries are available. Incomplete documentation also can delay reimbursement.

A carelessly prepared or incomplete medical chart endangers the patient and compromises the defense of malpractice claims. Six charting problems physicians and nurses should avoid are:

Late Reports or Progress Notes. Progress notes or consultants' reports entered days or weeks after a visit are of little value. Late or absent progress notes or reports handicap the defense of malpractice suits. Expect plaintiffs' attorneys to challenge the credibility of notes written too long after a problem occurred.

Illegible Writing. An unreadable entry may be misinterpreted or overlooked. Misread physician orders can result in serious patient injuries. Illegibility in the chart may require the writer to give a deposition or appear at a trial to interpret notes.

Alterations. Hospital or office medical records never should be deliberately altered. Errors should be crossed out with a single line so that they still can be read. Changes should be signed (or initialed) and dated. No changes should be made in the medical record after notice of a claim has been received. When errors are discovered after a claim or potential claim is reported, the person who wrote the original entry should consult with a defense attorney.

Criticism of Others. The patient's chart is not the place to criticize treatment by other physicians or by nurses. A note not intended to be critical may appear accusatory because of poor word choice. An example that resulted in litigation began when a surgeon, referring to his open reduction for a non-union, wrote: "Open reduction was done to repair an obviously defective closed reduction by emergency physician." The

surgeon intended to say the closed reduction, although done properly, was not successful. This misinterpreted note was the patient's incentive for a costly—and ultimately unsuccessful—malpractice action against the emergency physician.

Subjective Remarks. Objective language always should be used in the chart. A note which says the patient "uses excessive alcohol," but does not indicate the amount of alcohol intake may be disputed and criticized. Consider the difference between a note that describes the patient as "a malingerer," and a more objective entry: "I am unable to find any objective explanations for patient's subjective complaints of . . ." A patient may allege he was harmed as a result of a physician's or nurse's unsubstantiated subjective remarks in the chart.

Omission of Sensitive Information. Potentially embarrassing but medically significant entries about problems such as drug or alcohol abuse, sexually transmitted disease, and emotional or marital problems should not be omitted from the chart. Their omission could affect a cotreating physician's choice of treatment, medication, or anesthetics. When the omission of "sensitive" history or diagnoses disposes the patient to an injury by doctors or nurses unaware of the problems, the person responsible for the omissions may be held liable. To more tightly control release of sensitive information, consider putting it in a separate confidential file which is referenced in the primary chart and for which special authorization is required for release. (*Loss Minimizer*, June 1987, a publication of *Medical Liability Monitor*, June 23, 1989)

JUAs RUNNING DEFICITS RISE

Add two more state medical malpractice JUAs to the "in trouble" list of five reported by the Alliance of American Insurers in the February *MLM*. A just-released review of results by the Schamburg-based trade association reveals that, in addition to Massachusetts, New York, Rhode Island, New Hampshire, and South Carolina, Florida and Kansas are running deficits. Surpluses in 1986 of \$4.2 million and \$2.4 million in Florida and Kansas, respectively, now have been replaced with \$10.5 million and \$29,000 deficits. While the financial condition of joint underwriting associations in Massachusetts and New York were said to be deteriorating rapidly by Roger Kenney, AAI's research director, Rhode Island and New Hampshire improved their positions. Rhode Island reduced its deficit from \$81.2 million to \$74 million. New Hampshire cut its deficit from \$6.3 million to \$700,000. (*Medical Liability Monitor*, April 28, 1989)

RELIEF: RESPITE OR REALITY?

The "torrent of malpractice suits" has begun to ease, *The New York Times* reported. Writer Milt Freudenheim, in a balanced, well-researched report, said the result has been "a sharp decline in the number of multimillion-dollar jury awards for medical negligence, a drop in the number of malpractice claims and a reduction in overall spending for settling claims." The decline also is leading to some reductions around the country in physicians' premiums, Freudenheim said. Better risk management may be one reason, according to the article; so may be a "changed courtroom climate" as a result of tort reform legislation. Judges and juries also apparently have gotten the word that extremely high settlements are pushing up health costs. The documented downturn is a welcome respite after years of turmoil. It may not last, warns Dr. Brad Cohn, president of the Physician Insurers Association of America. He told *The New York Times* that a new crisis could develop in three years because "it is a cyclical condition." (*Medical Liability Monitor*, June 23, 1989) □

ROMA GREEN INTERIORS

ALLIED MEMBER A.S.I.D.

201-755-5287

FOR: AN EXPERIENCED DESIGNER OF MEDICAL OFFICES.

FOR: A COMFORTABLE AND BEAUTIFUL SUITE.

FOR: MORE EFFICIENT USE OF AVAILABLE SPACE.

FOR: PRACTICAL SOLUTIONS TO INDIVIDUAL SPECIALTY REQUIREMENTS.

RICHARD G. SCHMIDT, M.D.

is pleased to announce
the *relocation* of his

Musculoskeletal Tumor Practice

from

the Hospital of the University
of Pennsylvania

to

the Graduate Health System

520 South 19th Street

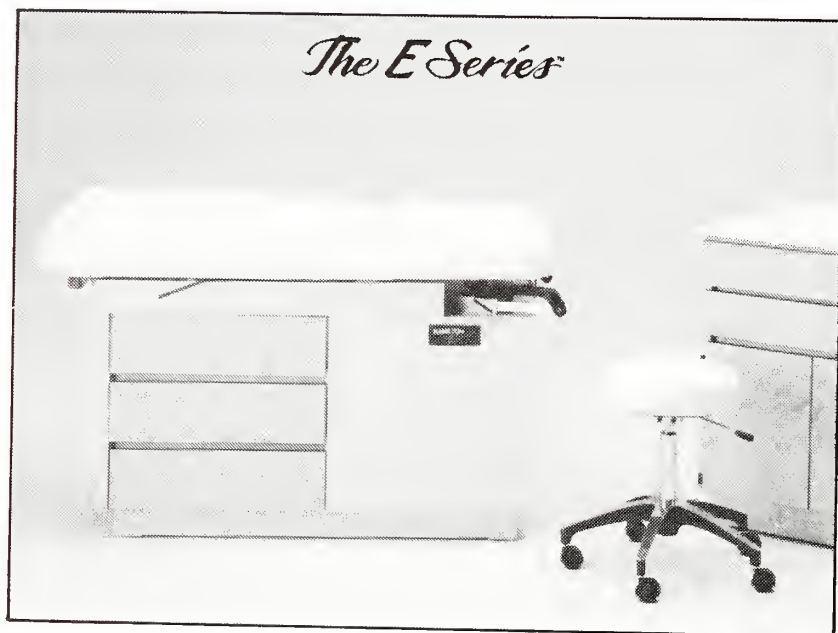
Second Floor

Philadelphia, Pennsylvania 19146

215-732-9005

High quality that doesn't cost an arm, a leg, a mint or a million!

The E Series



The Hamilton E-Series™ proves that a high-quality examination table doesn't have to cost a lot.

Ergonomically engineered and affordably priced, the E-Series maximizes efficiency while presenting a clean, professional image.

Its seamless style helps control contamination, and the foam-in-place top means no separating, wrinkles, or breakdown. Contemporary new colors will enhance your office, too. And a three-year warranty ensures your satisfaction.

High quality at a price that isn't — that's the Hamilton E-Series examination table. Call Today.

By **HAMILTON**
INDUSTRIES

**Call our local representative at
1-201-852-5067, or call the
Hamilton Medical Sales Division
at 1-800-888-5567**

AM-1092 Sep89 USA



PRESIDENT'S PAGE

PRESIDENT'S HOTLINE

The *President's Hotline*, containing current information about important issues, recently has been mailed. I have been gratified at the strong and positive response that it has elicited.

The *President's Hotline* is a bulletin providing a means to keep our membership informed on a more timely basis than this President's Letter allows. Because of the lead time necessary for *NEW JERSEY MEDICINE*, many areas in our rapidly changing environment cannot be covered adequately.

For example, we continue to give the highest priority to our opposition to the proposed surcharge on professional liability insurance. As indicated in the *President's Hotline*, we believe the insurance commissioner's proposal is "unacceptable, illegal, and unfair." At the time the *Hotline* was issued, it was stated that: "If the commissioner does not adopt an acceptable rule, the Society will file suit shortly." By the time you read this, I expect that one of these alternatives will have occurred. We will not abandon our membership on this issue! I believe we will prevail!

In the same recent *Hotline* issue, we noted our continued opposition to recent medical waste regulations that would require physicians to pay \$528 to register with the Department of Environmental Protection (DEP). This fee is unreasonable and we oppose it! We hope to obtain an acceptable modification of this fee. If not, we plan to file suit.

Other ongoing problems include the Medicare transition to Pennsylvania Blue Shield; Pennsylvania Blue Shield's policy with regard to assistants at major surgery; the incursion of the State Board of Physical Therapy into medical practice (case now pending in the Supreme Court); and licensure reform (Senator Codey's bill).

I will try to keep you informed on these and other issues through the *President's Hotline* and through this column. If you have specific questions at any time, please write to me.

The recent issue of the *President's Hotline* has been sent to an expanded audience, including the Board of Trustees, the House of Delegates, all AMA delegates and alternate delegates, the presidents of all hospital medical staffs, members of the Hospital Medical Staff Section, and presidents and executive directors of all county medical societies and specialty societies. The information should be made available to all members, through these groups and individuals. If there is sufficient interest in the *Hotline*, we may consider expanding the mailing list in the future.

BOARD MEETINGS

The very best way to stay informed about current issues affecting the medical community and medical care of New Jersey is to attend our monthly Board of Trustees' meetings. These meetings are open to the entire membership. Any member of the Medical Society may attend, and may speak before the Board. We do request that you inform us

beforehand, to allow scheduling on the agenda, if you plan to bring new topic before the Board of Trustees. The Board meetings are held on the third Sunday of each month. We will look for you there.

ELECTION TIME

We now are in the midst of a political campaign. This is a particularly busy time in the political calendar; but "politics" continues throughout the year. We must continue to participate in the political process, in the legislative and regulatory processes, if we are to continue to preserve and defend access to quality medical care for our patients. I again urge all physicians and their families to participate at the most basic level register and vote! The Medical Society of New Jersey Auxiliary has been particularly active in increasing voter registration among our membership and I am grateful to them for that. Participate also by supporting the candidates of your choice. Support them with your time and your efforts. Support them with your financial contributions. The Medical Society of New Jersey does not select or endorse specific candidates, but we do encourage individual members to do so.

You also can participate by supporting JEMPAC (the New Jersey Medical Political Action Committee). I expect that all members of your Board of Trustees and AMA Delegation will support JEMPAC this year; you should, too!

FORMICA CANDIDACY

The Board of Trustees of the Medical Society of New Jersey has endorsed the candidacy of Dr. Palma Formica for AMA Board of Trustees. Dr. Formica has represented our membership as a leader in this Society for many years, as a member of our AMA Delegation, and as president of this Society. I believe that she would serve our interests with the same dedication and commitment on the AMA Board of Trustees. I wish her luck, and will personally work hard for her election. □



EDITOR'S DESK

A DILEMMA

There are many reasons for the existence of a medical journal. *NEW JERSEY MEDICINE* has delineated its *raison d'être* on many occasions, most recently in the April 1989 issue, where we encouraged increasing dialogue between the journal and its readers. Although the editor has the right to reject submitted material, letters to the editor and comments on socioeconomic matters are interred with the greatest reluctance.

To suggest that "abortion" is a hot topic should come as no surprise. To suggest that some of our membership have submitted comments on abortion should likewise elicit no astonishment. But these comments create a dilemma for us—to ignore them would be cavalier; to publish them, in our humble opinion, would serve little useful purpose.

The philosophic differences between the Right-to-Life and the Freedom-of-Choice groups lend themselves to no easy resolution because the differences are fundamental. One group's morality, whether based on religious principles or not, brooks no deviation from the concept of good versus evil; it is not debatable, being based upon a natural law and irrefutable ethics. The second group, perhaps relying more on constitutional law, rejects the scientific conclusions of the other as being unproved, and champions the rights of the individual in his battle against unwarranted oppression by the state. (If this seems an oversimplification, we agree.)

This observer is not optimistic about the chances for a true reconciliation between the two factions. We have not determined what life consists of, let alone when it begins. On reflection, this is perfectly consonant with the difficulties we have encountered in defining death, the other end of our journey. The definition of death undoubtedly will be resolved legally, with much disagreement and with total pragmatism according to the mores of the day. The determination of the onset of life is likely to undergo the same resolution. And the dissension will continue.

The comparative rights of the individual and of the state are even more apt to be resolved pragmatically and politically. Whatever the decision, it will not terminate debate, which will ebb and flow with the changing times and with the intensity of the efforts of interested parties.

I find myself keeping company with a number of you—disturbed about some moral and ethical aspects of abortion while simultaneously demanding that government allow a true measure of personal freedom to its citizens. This schizophrenia seems almost to warrant a Solomonic decision, but this time the baby and the mother may be bisected.

It is not necessary that MSNJ be further polarized. The division is there and well recognized. It was demonstrated at the Annual Meeting in April and undoubtedly will be shown at other appropriate forums. But *NEW JERSEY MEDICINE* is not one of the proper venues for debate, absent new and previously unpublished material. We thank those who have written us on this topic and hope this editorial is acceptable in lieu of publication or a personal reply. O tempora! O mores! □



BOOK REVIEWS

ASTHMA *Peter J. Barnes, Ian W. Rodger, Neil C. Thomson (eds). New York, N. Academic Press, 1988.* The preface of this multiauthored authoritative text states its goal is to bring together recent advances in the understanding of biochemical, pharmacological, physiological, and cellular processes in asthma and its therapy. The editors and an international group of 41 other investigators have compiled a well-written, comprehensive but succinct state-of-the-art monograph. This has been achieved in 769 pages composed of 42 chapters divided into seven parts; there is a complete index. Much of the information is available in other recent monographs including chapters written by many of the same authors. This is reflected by the bibliographies not containing references more recent than 1986.

The initial 25 chapters and 443 pages are cohesive descriptions of the structure and function of the airways and their cellular constituents, the origins of the inflammatory and chemical mediators, as well as neural and humoral mechanisms of asthma. The biochemical basis of smooth muscle contraction is detailed nicely. The remaining three parts and chapters make up a coherent presentation of the pathogenesis and management of acute and chronic asthma including detailed discussions of the therapeutic agents currently available. *Asthma: Basic Mechanisms and Clinical Management* is recommended for those involved in the care of patients with asthma. □ Monroe S. Karetzky, MD

CECIL REVIEW OF GENERAL INTERNAL MEDICINE

Lloyd H. Smith, Jr, MD, and James B. Wyngaarden, MD. Philadelphia, PA, W.B. Saunders Company, 1989. This fourth edition contains approximately 900 new questions with seven new contributors. The softcover book, about 1/2-inch thick and close to telephone book size, has 12 sections, providing questions, answers with brief discussions, and a bibliography list (varying from one page to a single reference). Test sheets also are provided. There are no norms or grades; it is for self-discovery, not comparison to others. The text is recommended for physicians preparing for examinations or maintaining competence in practice. Continuing medical education chairmen can use this book as a discussion series by chapters in a community hospital just as the MKSAP series evolved into courses around the country. Question the audience and experts.

Are the questions and answers of such quality as to interest an experienced internist? The impressive credentials of the contributors have led to this. Keep in mind that in your area of expertise the questions may seem easy, but do not finish until you have tried a less familiar section: cardiovascular; respiratory; renal; gastrointestinal; hematology and oncology; genetic and metabolic; endocrinology and diabetes mellitus; infectious disease; clinical immunology and rheumatology; neurology; and dermatology. The answer paragraphs also guide the reader to a chapter number and author in the 18th edition of this text without specifying a page or paragraph. Nonetheless, asking questions is a superb way to learn. □ Morris Soled, MD

The Race for Governor

JIM COURTER

Monitoring physician performance. I am supportive of the efforts by the health care community to strengthen its present system of self-discipline in order to ensure that patients receive the highest quality medical care available.

Unfair surcharge on medical malpractice premiums. I understand physicians' objections to financing shortfalls in the Medical Malpractice Reinsurance Association through surcharges on all New Jersey physicians, even if they did not belong to the association. If legislation is necessary to address this issue, I would certainly prefer a proposal which does not place the financial burden on physicians who were not involved with the creation of the deficit.

Medicare cap. I am certainly aware that due to budgetary constraints at the federal level, Medicare reimbursements to physicians have not kept up with the cost of providing health care to Medicare beneficiaries. I also realize that many physicians have experienced problems with the administration of the Medicare program through the Health Care Financing Administration (HCFA). In Congress, I have worked with doctors to resolve their individual problems with Medicare reimbursements. In addition, earlier this year, I requested that Dr. Louis

JAMES J. FLORIO

Our state, its hospitals, physicians, nurses, and other health professionals always have been leaders in providing excellent care to its citizens. Continued confidence in the health care network is fundamental to our state's future development.

Americans spend almost 12 percent of the gross national product on health care, more than any other country. This year, \$600 billion will be disbursed on our nation's health. Yet, more than a million New Jerseyans continue to have no financial protection from the expenses of medical care—no insurance or other coverage, public or private.

No citizen of this state should be deprived of necessary care or be worried about seeking such care because of inability to pay. I have long been concerned about controlling the high cost of health care, and insuring that our children, seniors, and poor are able to receive affordable care.

I believe we must act quickly to lift this burden from the shoulders of our state's citizens. We need a health care strategy which is preventive in nature, comprehensive in scope, and economically viable. For all these reasons, I propose GOODHEALTH, a ten-point plan to control health care costs:

- Focus efforts on expanding prenatal and child health care to combat the state's high infant mortality rate.

- Encourage the development of comprehensive long-term care insurance packages to meet the needs of New Jersey's growing population of frail elderly and disabled residents. A Florio administration will also establish a comprehensive system of licensure for all home health care and long-term care agencies.

- Establish at least two more trauma centers to aid the more than 8,000 New Jerseyans who suffer major traumatic injuries yearly.

- Emphasize a greater reliance on the principles of preventive medicine. This emphasis is best implemented through health departments and com-

These statements were prepared by the two candidates running for governor in New Jersey: Jim Courter and James J. Florio. (Due to space restrictions the statements were edited as necessary.) NEW JERSEY MEDICINE is not endorsing either candidate; we simply are publishing their statements as a public service, to inform and educate our readers. Election day is November 7, 1989.

Courter continued.

Sullivan, Secretary of the Department of Health and Human Services, dispatch a special team from HCFA to resolve the Medicare reimbursement crisis in New Jersey.

Medical Society's Senior Courtesy Program. I am aware of the Medical Society's Senior Courtesy program. I commend the Medical Society of New Jersey for its commitment to ensuring that low-income senior citizens have access to needed medical care. I would welcome any additional information the Medical Society could provide with regard to this important program.

Mandatory assignment bill. No, I do not support mandatory Medicare assignment. While mandatory Medicare assignment might help lower costs to patients in the short run, in the long run it would likely hurt the very people we are trying to assist by lowering the quality of health care available and decreasing access to doctors. If physicians consistently lose money treating Medicare patients, they either will stop treating them or shift the costs to non-Medicare patients. I would prefer a system of incentives for doctors who choose to accept Medicare assignment, as is done currently.

Health commissioner qualifications. I strongly believe that top officials in the Department of Health should be licensed physicians in order to bring their expertise and firsthand knowledge of health care issues to decisions affecting health care delivery in New Jersey. However, I do not consider it essential for the commissioner, in particular, to be a licensed physician. I believe that individuals with strong backgrounds in the health care field and extensive experience in hospital administration, for example, should be eligible for consideration for the post of commissioner.

Diagnosing and treatment. Any changes in the requirement that physicians be the ones who perform such services should be examined very carefully with the quality and reliability of health care for all New Jerseyans being the most important factor.

Medicaid funding. I believe that every effort should be made to promote inoffice/outpatient treatment for Medicaid patients whenever medically feasible. Not only should our hospitals be reserved for acute care and specialized treatments, inoffice treatment is financially more responsible while providing more personalized treatment.

Malpractice settlements. I support structured settlement legislation for pain and suffering for all plaintiffs in liability cases. I believe it is equally important that regular cost awards are awarded to the plaintiff upfront. Structured settlement legislation is just one example of the many tort reforms needed to overhaul the entire insurance system in our state. ■

Florio continued.

munity hospitals and will be an initiative to slow the rise in health care costs.

- Develop a fully-coordinated battle plan to address the AIDS epidemic in New Jersey within the first six months of a Florio administration. My AIDS prevention and control plan will include community education, outreach to individuals and groups at risk of this disease, inventory of AIDS-related service coordination of all AIDS activity between and among state agencies, alternatives to expensive and inappropriate hospital care, and personnel to work with AIDS patients and their families.

- Find more efficient and more responsive solutions to the problem of New Jersey's uninsured. By ensuring that the medically uninsured begin to receive adequate health care, we can begin to reduce their total health care costs.

- Improve access to primary care physicians. I propose the formation of loan forgiveness program for medical students who agree to locate their primary care practice in physician shortage areas. There should also be an active expansion of neighborhood health initiatives by local hospitals to address the diverse and complex health care needs of the communities they serve.

- Create a Governor's Council to examine the entire question of hospital reimbursement in New Jersey. Reimbursement reform will be a major priority of my administration. By planning for our hospitals' future today and providing them with firm financial footing, we can help to decrease the overall costs of our state's health care.

- Focus efforts on stemming the enormous burden of Medicare costs for doctor's bills on the elderly and the economy. Congress currently is developing a rational system of payment to doctors, to control growth in expenditures and limit the burden on Medicare beneficiaries. In doing so, it is crucial that older Americans be protected from increases in our out-of-pocket costs from balance billing. At a minimum, their phasing out of balance billing should be part of any new reimbursement system, and I am committed to insuring that our seniors receive the best care at the most affordable level possible.

- Reorganize the state Department of Health to become more responsive to the needs of the hospital industry, physicians, and, ultimately, our citizens. The next commissioner of health will have the education and professional background to understand the two major issues which confront us—health care economics and public health.

GOODHEALTH offers a solid strategy to combat rising health costs and provide quality, responsive health care. I'm looking forward to continuing to work with you in developing a comprehensive health care policy for the 1990s and beyond. ■

Alcoholic Cardiomyopathy

ROBERT M. KOSINSKI, MD

The natural course of alcoholic cardiomyopathy is one of progressive left ventricular dysfunction and early demise. The author reports a case of normalization of severe left ventricular dysfunction over a prolonged period in a patient with alcoholic cardiomyopathy who abstained from alcohol.

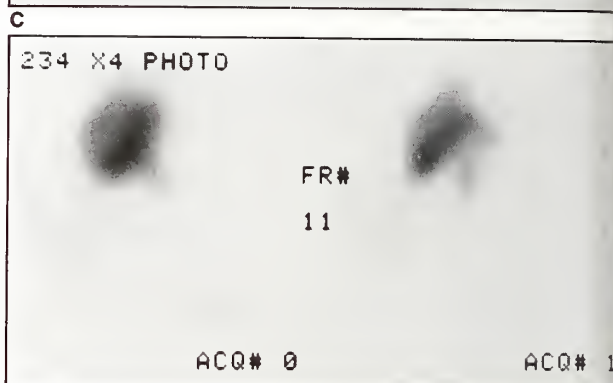
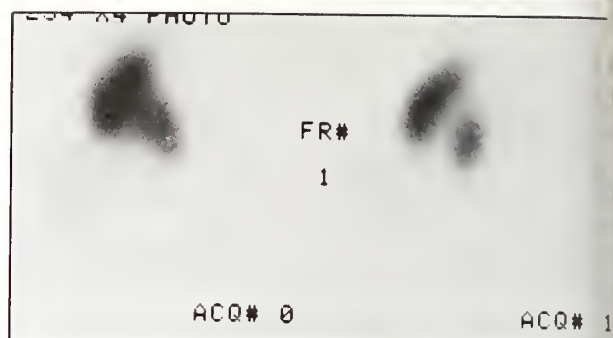
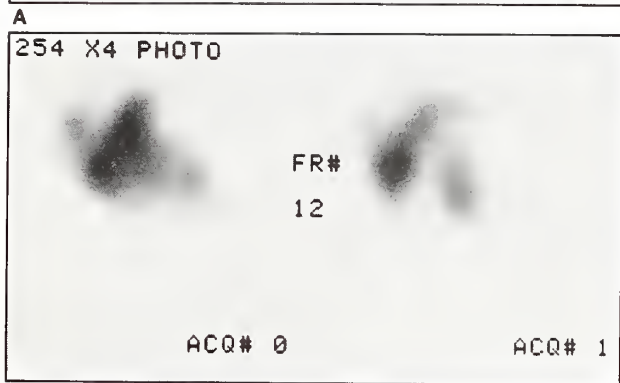
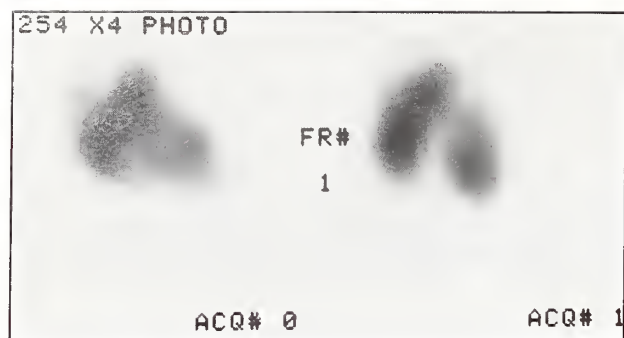
A 37-year-old male presented with a two-month history of progressive bilateral leg swelling, increasing abdominal girth, dyspnea on exertion, orthopnea, and paroxysmal nocturnal dyspnea. The patient had a previous history of an alcohol-related seizure disorder, but no history of coronary artery disease, hypertension, or recent viral illness. The patient had an 18-year history of heavy alcohol intake, with daily consumption and frequent weekend binge drinking. He also had a 25 pack year history of cigarette smoking. The patient had been seen approximately one month prior to

admission in the medical clinic; at that time, he was placed on oral spironolactone and vitamin B supplementation. At the time of admission, the patient was unable to walk more than a few steps without becoming acutely short of breath.

Examination revealed an anxious, well-developed male who was tachypneic with a respiratory rate of 30 breaths/min. The heart rate was 110 beats/min and regular, and the blood pressure was 120/60. Jugular venous distention was present, as were rales to the midlung fields bilaterally. An S3 gallop was present on cardiac examination. The liver was percussed to 14 cm. The extremities showed marked pitting edema to the groin, including the scrotum and penis.

On admission, the electrocardiogram (ECG) showed a sinus tachycardia, left ventricular hyper-

Dr. Kosinski is affiliated with the Department of Internal Medicine, Monmouth Medical Center, Long Branch. Requests for reprints may be addressed to Dr. Kosinski, Monmouth Medical Center, Long Branch, NJ 07740.



Figures 1A-1D. Anterior and 45-degree left anterior oblique views of nuclear gated heart pool scans taken at (A) end diastole and (B) end systole at time of initial presentation showing global hypokinesia and a LVEF of 12 percent. Repeat study 23 months later showing normal wall motion with a LVEF of 69 percent (C = end diastole, D = end systole).

trophy, and diffuse ST segment changes with T wave inversions. A chest x-ray revealed evidence of congestive heart failure and cardiomegaly with a cardiothoracic ratio of 0.58. Laboratory values showed elevated transaminase levels, with normal hemoglobin, protein, and albumin.

In the absence of other known cardiac disease, and knowing of the patient's substantial alcohol consumption, a presumptive diagnosis of alcoholic cardiomyopathy was made. The patient was admitted and treated with intravenous furosemide, oral spironolactone, and digoxin. An echocardiogram showed poor ventricular function but no evidence of a pericardial effusion. A multigated cardiac scan (MUGA) performed at rest on hospital day six showed severe biventricular dysfunction with dilatation in systole and diastole. The left ventricular ejection fraction (LVEF) was 12 percent (NL > 55 percent) and a right ventricular ejection fraction (RVEF) was 16 percent (NL > 45 percent) (Figures 1A and 1B). The patient responded well to diuresis with a 13.2 kg total weight loss and was discharged on hospital day seven on oral furosemide, digoxin, spironolactone, and potassium supplement. At that time, the patient also was referred for evaluation as a possible candidate for cardiac transplantation.

At followup three months later, the patient had remained free of alcohol consumption and his symptoms improved gradually. A resting MUGA scan at that time showed continued left ventricular dys-

function with global hypokinesia, but some improvement in LVEF to 25 percent, and RVEF to 38 percent. A repeat chest x-ray after 11 months of abstinence showed resolution of cardiomegaly with a cardiothoracic ratio of 0.43. On examination, the patient's lungs were clear, no third heart sound could be appreciated, and peripheral edema no longer was present. All medications were discontinued at that point. After 23 months of abstinence, a resting MUGA scan showed mild left ventricle (LV) enlargement with normal wall motion and a LVEF of 69 percent. Right ventricular size was normal and the RVEF was 62 percent (Figures 1C and 1D). The patient's ECG continued to show left ventricular hypertrophy, diffuse ST segment abnormalities, and T wave inversions.

DISCUSSION

Alcohol is the major cause of secondary, nonischemic dilated cardiomyopathy in the western world, and has been implicated in reports of sudden death or ventricular fibrillation in young alcoholics with no history of cardiac disease. Alcoholic cardiomyopathy is a disease characterized by severe left ventricular dysfunction and a poor prognosis. In one study, the overall mortality at 36 months was 42 percent, and in those patients with a deterioration of functional class, the mortality rate at 36 months was 80 percent.¹

In normal individuals, consumption of 60 gm of alcohol over a two-hour period has been shown to increase the force of myocardial contraction.^{2,3} Studies have shown alcohol to have a direct toxic effect on the cardiac muscle causing mitochondrial damage with a decrease in oxidative enzymes and diminished energy production. Alcohol leads to generalized swelling of the sarcoplasmic reticulum with increased calcium delivery and impaired excitation/contraction coupling leading to diminished contractility.^{4,5} Alcohol also has been shown to interfere with myocardial lipid metabolism, protein synthesis, and ATPase activity.⁶ Acetaldehyde, the main metabolite of alcohol, has been shown to cause myocardial norepinephrine release and subsequent catecholamine depletion, which further may contribute to diminished contractility.⁷ Acutely, the depressive effects of alcohol have been shown to be rapidly reversible with hemodialysis.⁸ Also, myocardial depression may be clinically asymptomatic, though pathological evidence of cardiac disease may be manifested by varying degrees of interstitial fibrosis in chronic alcoholics.⁹

The criteria for the diagnosis of alcoholic cardiomyopathy have been proposed as congestive heart failure in patients under 50 years of age; no evidence of the usual causes of cardiac disease to explain ventricular dysfunction; and a history of prolonged consumption of excessive amounts of alcohol.^{1,10} Although viral studies or invasive diagnostic procedures were not performed, this patient had no history of hypertension or other known cardiac disease and, at his age, atherosclerotic heart disease would be unlikely.

Several reports have demonstrated improvement in left ventricular function and clinical symptomatology in patients with alcoholic cardiomyopathy who have abstained from alcohol.¹¹⁻¹³ However, normalization of severe left ventricular dysfunction

in these patients for a prolonged period rarely has been reported. Schwartz et al. reported a case of reversal of severe alcoholic cardiomyopathy in which the LVEF increased from 14.9 percent to 72.5 percent over a period of one year of abstinence as documented by cardiac catheterization.¹¹ However, at the time of initial catheterization, the patient's rhythm was that of atrial fibrillation; while at the time of repeat catheterization, the patient was in normal sinus rhythm and was on oral digoxin therapy. Although not used in this patient, angiotensin-converting enzyme (ACE) inhibitors, such as captopril, have shown to be beneficial in both congestive heart failure and dilated cardiomyopathy.

The resolution of cardiomegaly also has been documented previously in patients with alcoholic cardiomyopathy who abstained from alcohol. In one study, heart size returned to normal limits (cardiothoracic ratio < 0.50) in 45 percent of patients at rest. However, within mobilization of these patients, only 21 percent remained with a normal heart size.¹

SUMMARY

Although alcoholic cardiomyopathy usually carries a poor prognosis, a good outcome can be obtained for a prolonged period with abstinence from alcohol. ACE inhibitors also are beneficial and should be used if tolerated by the patient. This patient presented with factors associated with a favorable prognosis, namely, a short duration of symptoms and abstinence from alcohol.¹⁰ It should be noted that although this patient's cardiac function improved significantly, ECG abnormalities persisted, demonstrating the lasting effects alcohol has on the myocardium. Also, patients who return to their previous excessive drinking patterns after a period of abstinence have been shown to have deterioration of their cardiac function.^{12,14} ■

REFERENCES

1. Demakis J, et al.: The natural course of alcoholic cardiomyopathy. *Ann Intern Med* 85:293-297, 1974.
2. Ahmed SS, Levinson GE, Regan TJ: Depression of left ventricular contractility with low doses of ethanol in normal man. *Circulation* 48:378-385, 1973.
3. Delgado CE, Fortuin NJ, Ross RS: Acute effects of low doses of alcohol on left ventricular function by echocardiography. *Circulation* 51:535-540, 1975.
4. Wendt VE, Wu C, Balcon R, et al.: Hemodynamic and metabolic effects of chronic alcoholism in man. *Am J Cardiol* 15:175, 1965.
5. Schwartz MH, Repke DI, Katz AM, Rubin E: Effects of ethanol on calcium uptake by cardiac microsomes. *Biochem Pharmacol* 23:2369, 1974.
6. Wenger WK: Myocardial involvement in systemic disease: Ethyl alcohol, in Hurst, JW, et al., *The Heart*. New York, NY 1974, p. 1366.
7. James TN, Bear ES: Effects of ethanol and acetaldehyde on the heart. *Am Heart J* 74:243, 1967.
8. Symbas PN, Tyras DH, Ware RF, Baldwin BJ: Alteration of cardiac function by hemodialysis during experimental alcohol intoxication. *Circulation* 2:227, 1972.
9. Hognestad J, Tiesberg P: Heart pathology in chronic alcoholism. *Acta Pathol Microbiol Scand* 81:315, 1973.
10. McDonald CD, Burch GE, Walsh JJ: Alcoholic cardiomyopathy managed with prolonged bed rest. *Ann Intern Med* 74:681-691, 1971.
11. Schwartz L, Sample KA, Wigle ED: Severe alcoholic cardiomyopathy reversed with abstinence from alcohol. *Am J Cardiol* 36:963-966, 1975.
12. Kupari M: Reversibility of alcoholic cardiomyopathy. *Grad Med J* 60:151-154, 1984.
13. Agatston AS, Snow ME, Sarnet P: Regression of severe alcoholic cardiomyopathy after abstinence at ten weeks. *Alcoholism* 10:386-387, 1986.
14. Read R, Bell J, Batey R: Cardiac function assessed by gated heart pool studies in an alcoholic clinic population. *Alcoholism* 8:467-469, 1984.

**“A fee-for-service insurance program
with complete office coverage?”**



**I don't
believe it.”**

Gastrostomy Tube-Feeding

MICHAEL A. NEVINS, MD

This study reports on the 12-month experience with one form of artificial feeding, gastrostomy, at a 250-bed community hospital.

In a landmark decision (*in re Conroy*, 1985), New Jersey's Supreme Court observed that "artificial feedings such as nasogastric tubes, gastrostomies, and intravenous infusions are significantly different from bottle-feeding or spoon-feeding—they are medical procedures with inherent risks and possible side effects."¹

Four years later, there has been near unanimous support for this position from high courts throughout the land as well as by many major professional and scholarly groups.^{2,3} Nonetheless, a hard core of critics fear the courts have started down "a slippery slope" that may lead to devaluing human life. They argue that fluids and nutrition are basic to life and to withhold or withdraw them either would cause new suffering or death by starvation. On the other hand, introduction of a feeding tube is viewed by them to be a relatively innocuous, low-technology procedure that can only benefit the patient.

This study reports on the 12-month experience with gastrostomy, at Pascack Valley Hospital, a 250-bed community hospital.

METHODS

Hospital records of all patients who had feeding-tube gastrostomies performed from February 1988 through January 1989 were reviewed and followup

discussions held with attending physicians. Record review was performed 1 month after the end of the study period; the interval between gastrostomy and review varied between 1 and 14 months.

RESULTS

Twenty-six patients, aged 60 to 96 years, had gastrostomies performed: 10 gastrostomies performed as an operating room procedure and 16 gastrostomies performed by percutaneous endoscopic technique (PEG). Four patients had mechanical obstruction due to carcinomas of esophagus, larynx, and lung, or advanced scleroderma. Twenty-two patients had severe neurologic disease associated with dysphagia (11 patients after an acute cerebrovascular accident, 10 patients with Alzheimer's disease or multi-infarct dementia, 1 patient after traumatic fracture of cervical vertebrae). Eleven patients, residents of long-term care facilities, were hospitalized because of an acute medical condition; 3 patients were hospitalized for gastrostomy.

Fourteen patients (54 percent) died. Of the 4 patients with mechanical obstruction, 1 patient still was alive 9 months after gastrostomy, 2 patients died in the hospital, and 2 patients died at home. Of the 22 patients with nonobstructive neurologic disorders, 11 patients (50 percent) died, 3 patients died during the same hospitalization, and 8 patients died in a nursing home within 3 months after the procedure. Of these 11 deaths, 9 deaths occurred

Dr. Nevins is affiliated with UMDNJ-New Jersey Medical School. Requests for reprints may be addressed to Dr. Nevins, 400 Old Hook Road, Westwood, NJ 07675.

within three weeks of the gastrostomy. At the time of the study, 8 patients were still alive at 12, 12, 3, 3, 3, 2, and 1 months after the gastrostomy, respectively. Followup was unavailable for 3 patients.

Clinical evidence of aspiration pneumonia occurred in 14 patients (54 percent). Although none had postmortem examinations and other factors may have contributed, death probably was related to aspiration in 4 patients and possibly related to aspiration in at least 2 other patients. Aspiration pneumonia frequently occurred within a few days of gastrostomy and appeared to be more likely when continuous infusions were maintained at rates of more than 75 cc/hr.

CASE REPORT

A 96-year-old woman living at home was in gradual mental and physical decline. She became increasingly agitated, began to refuse food, and declared that she wanted to die. She soon became dehydrated and poorly responsive; she was brought by her family to the hospital's emergency room. The patient was admitted and rehydrated but when she became more alert, she still refused oral feedings. When advised that a feeding tube might be necessary, she cried, "No, No, No!" Her family submitted a letter requesting no artificial feeding other than by intravenous infusion. Weeks went by, the patient declined further, but no other treatable medical condition was identified. The hospital's utilization committee declined further hospital stay and the family agreed that a nursing home would be appropriate. However, no nursing home would accept her unless tube-feeding was begun in the hospital. The family relented and three weeks after admission a PEG procedure was performed. Continuous tube-feedings gradually were increased to a rate of 100 cc/hr. Three days after the gastrostomy, she developed cough, congestion, and fever. Despite antibiotic treatment, she died two days later of probable aspiration pneumonia.

DISCUSSION

Enteral feeding by gastrostomy tube generally has been preferred to nasogastric tube-feeding because it is thought to be less uncomfortable, obviating the need for hand restraints, and less likely to be associated with aspiration. This small clinical study

is flawed by the usual difficulties inherent in retrospective chart review. However, an incidence of aspiration pneumonia in about half of the cases is striking and is consistent with other recently published studies.

One report of 70 elderly patients at a skilled nursing facility found that aspiration pneumonia occurred with equal frequency (43 percent) whether fluids were delivered via a nasogastric gastrostomy tube.⁴ Other complications frequently encountered included tube dysfunction (50 percent) and agitation/extubation (44 percent with nasogastric tubes). Mortality during the 11-month study period was 40 percent and only 11 patients could be maintained alive for more than one year. Other reported complications of tube-feeding include pneumonia, diarrhea, metabolic abnormalities, and, less frequently, epistaxis, pneumothorax, hydrothorax, nasal alar necrosis, nasopharyngitis, esophageal strictures, and airway obstruction.

A study of terminally ill elderly patients with severe progressive neurological diseases, e.g., Alzheimer's disease, from a Canadian rehabilitation center made a strong case against all forms of tube feeding since it frequently results in the very outcome it is intended to prevent—aspiration.⁵ The policy of palliative care for this category of patients who have reduced caloric needs provides enriched puddings by frequent spoon feedings. Over a three-year period this rarely was associated with aspiration and tube-feedings were necessary in only three patients; all three patients died of autopsy-proven aspiration bronchopneumonia.

The message of this report is not that gastrostomies should not be performed. Rather, with all forms of medical treatment, both its risks and its benefits should be carefully balanced within the clinical context. Gastrostomy tube-feeding frequently causes important medical complications which, themselves, may cause death. For those who already are near death or are permanently unconscious, it offers few, if any, meaningful benefits. Since decisions to initiate or to withhold tube feeding rarely are black and white, and generally are shrouded by ambiguity, arbitrary regulations are ill advised. Instead, maximum discretion should be provided to the physician, patient, and family so that they can choose what in their collective judgment feels best. ■

REFERENCES

1. In re Conroy, 486 A, 2d 1209 (N.J. 1985).
2. Steinbrook R, Lo B: Artificial feeding—solid ground, not a slippery slope. *N Engl J Med* 318:286-290, 1988.
3. Arras JD: The severely demented, minimally functional patient: An ethical analysis. *J Am Geriatr Soc* 36:938-944, 1988.
4. Ciocon JO, Silverstone FA, Graver LM, Foley CJ:

Tube-feedings in elderly patients. Indications, benefits and complications. *Archives Intern Med* 148:429-432, 1988.

5. Campbell-Taylor I, Fisher RH: The clinical case against tube-feeding in palliative care of the elderly. *J Am Geriatr Soc* 35:1100-1104, 1987.

Left Atrial Myxoma

RAMZI A. TABBALAT, MD
JACOB I. HAFT, MD

Although atrial tumors usually present with cardiac symptoms, myxomas may cause only nonspecific systemic symptoms early in their course, before they are large enough to have a hemodynamic effect. Two-dimensional echocardiography can be useful when diagnosing is problematic.

The presence of an atrial myxoma usually is heralded by the development of symptoms due to obstruction of the mitral valve, such as heart failure, dizziness, or syncope associated with a change in body position after development of a new diastolic rumble.¹ Myxomas also may be diagnosed after a tumor embolism to a peripheral artery has occurred.² Although atrial myxomas frequently are associated with systemic symptoms such as fever, malaise, high sedimentation rate, and arthritis, they rarely are diagnosed when only these symptoms are noted.

When our patient presented with nonspecific systemic complaints, a two-dimensional echocardiogram revealed a left atrial myxoma.

CASE REPORT

A 38-year-old previously healthy Hispanic female had a two-week history of symmetrical arthralgias

Drs. Tabbalat and Haft are affiliated with the Department of Cardiology, Saint Michael's Medical Center, Newark. Requests for reprints may be addressed to Dr. Haft, Saint Michael's Medical Center, 268 Martin Luther King Jr. Blvd., Newark, NJ 07102.

involving the large joints of the upper and lower extremities and back, associated with generalized malaise, easy fatigue, and occasional feverishness. The patient denied weight loss, intravenous drug abuse, skin rash, palpitations, syncope, or dyspnea. There was no past history of rheumatic fever, heart murmur, or connective tissue diseases. After a two-week period on a nonsteroidal anti-inflammatory drug, the patient reported no improvement in her condition. An M-mode echocardiogram was normal; a two-dimensional echocardiogram revealed a small pedunculated mass in the left atrium attached to the interatrial septum and not prolapsing through the mitral valve (Figures 1 and 2). Color flow and continuous wave Doppler examination did not reveal any abnormal flow and the remainder of the study was normal. The patient was admitted to Saint Michael's Medical Center. On admission, she was afebrile with blood pressure of 110/80 mm/Hg and a pulse of 88/min. There was no carotid bruit or jugular venous distension. Cardiac auscultation performed in the supine, left lateral, sitting, and standing positions was normal. No murmurs, gallops, or "tumor plop" were heard. The lungs were clear. The abdomen was within normal limits. No rash or club-

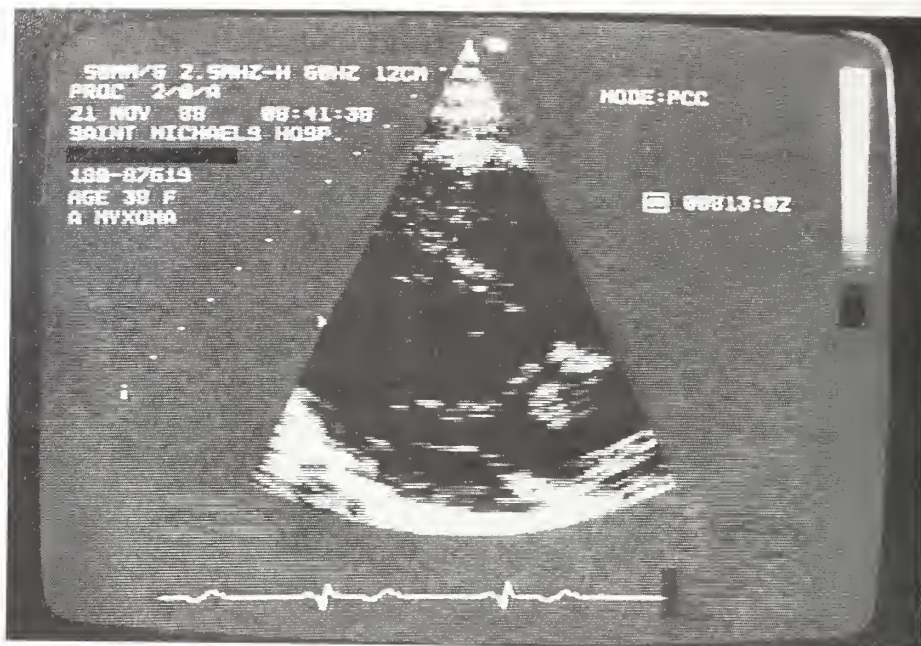


Figure 1. Long-axis, two-dimensional echocardiogram of the patient demonstrating the left atrial myxoma adjacent to the interatrial septum.

bing was noted and the musculoskeletal system was normal. Hemoglobin was 14.3 gm/dl; hematocrit, 41%; WBC, 9000/mm³ with normal differential; platelet count, 295,000/mm³; ESR = 21 mm in the first hour; and blood chemistry, normal. PA and lateral chest x-rays were normal. An electrocardiogram revealed normal sinus rhythm at 60/min with normal axis, wave forms, and intervals. Rheumatoid factor and antinuclear antigen titres were negative. Cardiac catheterization was performed. Opacification of the left atrium via a pulmonary artery contrast injection revealed a highly mobile pedunculated filling defect attached to the interatrial septum. Coronary angiography was normal. The patient was taken to surgery and a 3 x 2.5 x 2 cm mass was removed from the left atrium. Histologic examination was consistent with a benign myxoma. The patient returned for followup three months after discharge from the hospital; she was on no medications and was free of all arthritic or systemic symptoms.

DISCUSSION

Cardiac myxoma is the most common primary tumor of the heart, representing 30 to 50 percent of all primary intracardiac tumors.³ The first pre-mortem diagnosis of a myxoma was made by cardiac angiography in 1951,⁴ and the first successful surgical excision was performed in 1954.⁵

Myxomas occur most often between the ages of 30 and 60 years with a male to female incidence between 1:1 and 1:3.^{1,6} About 75 percent of myxomas are located in the left atrium, usually attached by a peduncle to the interatrial septum near the area of the fossa ovalis.⁷ And, 20 percent are located in

the right atrium,¹ with the remaining 5 percent found in either ventricle. Over 90 percent of myxomas are solitary, but multiple tumors can occur. Myxomas vary in size from a few mm to 10 cm in diameter. Most investigators now believe myxomas originate from the abnormal proliferation of "reserve cells" found in the endocardium that are primitive precursor cells normally differentiated into endothelial, smooth muscle cells or fibroblasts.² Myxomas, therefore, are considered true neoplasms rather than organized thrombi.² Although considered benign, myxomas frequently exhibit behavior characteristic of malignant neoplasms, such as local invasion and recurrence.⁹ Tumor emboli may lodge in the peripheral vasculature causing arterial aneurysms and pseudoaneurysms.⁹ Growth of these emboli may occur even after resection of the primary tumor.¹⁰

Histologically, myxomas appear as a hypocellular mass with a mucopolysaccharide matrix lined by a single layer of endothelium.² Occasionally, they contain histologically distinct gland-like elements with positive staining for carcinoembryonic antigen (CEA), epithelial membrane antigen (EMA), keratin, and factor VIII-related antigen.²⁴ PGP 9.5, a soluble protein isolated from the brain, has been identified in myxomas by staining techniques suggesting that neuroendocrine differentiation may be a feature of these tumors.¹² Chromosomal abnormalities also have been found in myxomas, supporting the concept that they are neoplastic growths.¹³

Myxomas usually present clinically with obstructive manifestations. Since most myxomas are left atrial, features mimicking mitral stenosis and less

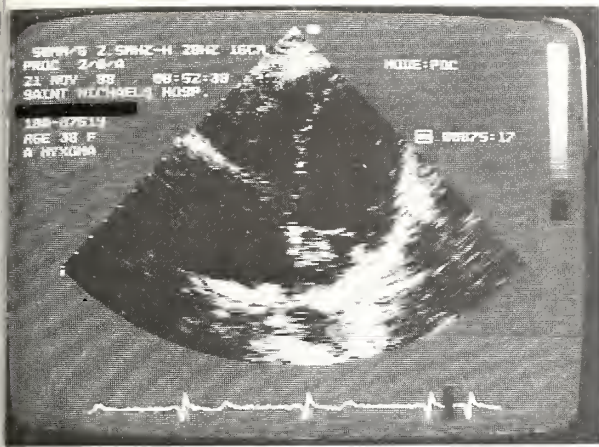


Figure 2. Four-chamber, two-dimensional echocardiogram demonstrating the left atrial myxoma adjacent to the interatrial septum.

Commonly mitral regurgitation are the most common.^{1,2,6} These include dyspnea, fatigue, weakness, syncope, and heart failure. Distinguishing features from mitral stenosis, with which it often is confused, include the presence on auscultation of a “tumor plop,” an early diastolic sound thought to be produced as the tumor strikes the ventricular endocardial wall as it prolapses through the mitral annulus, or as its movement through the mitral valve is abruptly halted. There may be a change in the intensity of the murmur and tumor plop with change in body position. Atrial fibrillation usually is absent; the patient denies a history of rheumatic fever and the murmur usually is new. Right atrial myxomas may produce features of tricuspid valve stenosis or regurgitation and right-sided heart failure. By obstructing the inferior vena cava, they can mimic a Budd-Chiari syndrome with hepatomegaly and ascites.¹⁴ Left ventricular and right ventricular myxomas may cause outflow tract obstruction producing signs and symptoms of aortic or pulmonary stenosis. Our patient had none of these signs or symptoms of obstruction, probably because the tumor still was small when it was discovered.

Embolic events also frequently lead to diagnosis of cardiac myxomas. Friable fragments of the tumor may detach from the surface of the myxoma and travel anywhere in the arterial system.⁶ 50 percent embolize to the central nervous system. Embolization to the peripheral circulation may cause infarction or hemorrhage of any organ, and small recurrent emboli may occasionally mimic systemic vasculitis. The diagnosis of cardiac myxoma should be considered in any patient presenting with systemic emboli.

Occasionally, the diagnosis of a myxoma is made after histologic examination of an embolus retrieved at surgery. Embolization to the coronary circulation may result in a fatal myocardial infarction.¹⁵ An infected myxoma can mimic infective endocarditis

with various embolic manifestations.¹⁶ Right-sided cardiac myxomas may cause recurrent emboli and pulmonary hypertension. Fortunately, our patient had no identifiable embolic phenomena.

The most common symptoms of cardiac myxomas are systemic and nonspecific. These are present in the majority of patients and include fever, myalgia, arthralgia, cachexia, muscle weakness, Raynaud’s phenomenon, rash, and clubbing.^{1,6} Laboratory findings include leukocytosis, thrombocytosis, thrombocytopenia, anemia, polycythemia, elevated erythrocyte sedimentation rate, hypergammaglobulinemia, hypocomplementemia, and the presence of antidouble-stranded DNA and antimyocardial antibodies. These manifestations are nonspecific, and often mimic other diseases, such as infective endocarditis, connective tissue diseases, vasculitis, or polymyositis. Although these systemic symptoms are common in patients with cardiac myxomas, there usually are associated cardiac and embolic manifestations that lead to suspicion of these tumors. We could not find any reports in the literature in which the diagnosis of a myxoma was suspected solely on the basis of the presence of arthralgias and malaise. It is expected, as in our patient, that the diagnosis of myxoma will be made more commonly in patients with these nonspecific complaints, who have a two-dimensional echocardiogram during their workup to rule out endocarditis, rheumatic fever, or myocarditis.

Two-dimensional echocardiography has become the method of choice for the diagnosis of myxoma and for followup of recurrences.^{2,7,17} It is both sensitive and specific and rapidly is replacing angiography because it is completely safe, comfortable, and noninvasive, and there are fewer false positive and false negative results.¹⁷ It is superior to M-mode echocardiography as it yields better quantitative and qualitative information.¹⁷ Since the introduction of two-dimensional echocardiography, the number of asymptomatic myxomas diagnosed by echocardiography steadily has increased. Continuous wave and color doppler ultrasonography may be helpful for evaluating valvular stenosis or regurgitation caused by the tumor.¹⁸ Catheterization and invasive angiography is indicated when echocardiography is equivocal or other cardiac diseases such as coronary artery diseases are suspected, and to confirm the presence of a nonocclusive myxoma, as in our patient.

Newer imaging techniques have been reported to effectively diagnose cardiac myxomas but none yet has proved to be superior to two-dimensional echocardiography. Gated magnetic resonance imaging (MRI) may be used to provide complimentary information to echocardiography.¹⁹ MRI can delineate the anatomic relationship of the tumor to

normal structures and its extent, and may be an alternative when an adequate echocardiogram cannot be obtained, in patients with a poor echocardiographic window or with chronic obstructive pulmonary disease. MRI offers the advantage of imaging the entire thorax, including the mediastinum, lungs, and great vessels.^{19,20}

Computed tomography (CT) has a limited role in the diagnosis of myxomas, and has no advantage over other modalities. Both CT and MRI are inferior to echocardiography as they are not as effective in diagnosing other cardiac diseases with which myxomas often are confused.

Bateman et al. described the use of cardiac cine-computed tomography in two patients with left atrial myxomas. The technique provided precise information about the size, location, site of attachment, and relation of the tumor to the mitral valve.²¹ However, the technique requires the intravenous administration of a large bolus of contrast material.

Once diagnosed, prompt surgical resection of the myxoma is necessary as complications can occur unexpectedly. The extent of surgical resection necessary to prevent recurrences is a matter of ongoing controversy. Some surgeons recommend simple ex-

cision while others stress the need for direct visualization of all four chambers via a biatrial approach. Any resultant septal defect is repaired with a pericardial or synthetic patch.

Recurrence of a myxoma after removal has been reported in up to 14 percent of patients.^{1,2} Recurrence may be single or multiple, occurring at the site of the primary tumor or in a completely different site or different cardiac chamber. Possible explanations for recurrence have included incomplete resection, multiple foci of growth, malignant transformation, peripheral embolization, and new growth of mesenchymal reserve cells.² Patients should have follow-up echos yearly after myxoma resection.

SUMMARY

A patient who presented with nonspecific systemic complaints unexpectedly was found to have a left atrial myxoma during workup that included a two-dimensional echocardiogram to rule out endocarditis. Current concepts regarding etiology, diagnosis, and management of cardiac myxomas are reviewed. The availability of two-dimensional echocardiography has added greatly to the ease and accuracy of diagnosing cardiac tumors. ■

REFERENCES

1. St. John Sutton MG, Mercier LA, Giuliani ER, Lie LT: Atrial myxomas, a review of clinical experience in 40 patients. *Mayo Clin Proc* 55:371-176, 1980.
2. Markel ML, Waller BF, Armstrong W: Cardiac myxoma. A review. *Medicine* 66:114-125, 1987.
3. Fabian JT, Rose AG: Tumors of the heart: A study of 89 cases. *South Afr Med J* 61:71-77, 1982.
4. Goldberg HP, Glenn F, Dotter CT, Steinberg I: Myxoma of the left atrium: Diagnosis made during life with operative and postmortem findings. *Circulation* 6:762-767, 1952.
5. Crafoord CL: Discussion on mitral stenosis and mitral insufficiency, in Lam CR (ed), *Proceedings of the International Symposium on Cardiovascular Surgery*. Philadelphia, PA, WB Saunders, 1955, pp. 202-211.
6. Bulkley BH, Hutchins GM: Atrial myxomas: A 50-year review. *Am Heart J* 97:639-643, 1979.
7. Dein JR, Frist WH, Stinson EB, et al.: Primary cardiac neoplasms. Early and late results of surgical treatment in 42 patients. *J Thorac Cardiovasc Surg* 93:502-511, 1987.
8. Martin LW, Wasserman AG, Goldstein H, et al.: Multiple cardiac myxomas with multiple recurrences: Unusual presentation of a benign tumor. *Ann Thorac Surg* 44:77-78, 1987.
9. Attum AA, Johnson GS, Masri Z, et al.: Malignant clinical behavior of cardiac myxomas and "myxoid imitators." *Ann Thorac Surg* 44:217-222, 1987.
10. DeSousa AL, Muller J, Campbell RL, et al.: Atrial myxoma: A review of neurological complications, metastasis, and recurrences. *J Neurol Neurosurg Psych* 41:1119-1124, 1978.
11. Goldman BI, Frydman C, Harpaz N, et al.: Glandular cardiac myxomas. Histologic, immunohistochemical, and ultrastructural evidence of epithelial differentiation. *Cancer* 59:1767-1775, 1987.
12. Davies MJ, Rode J, Woolf N, Krikler DM: Neuroendocrine differentiation in atrial myxomas. *Lancet* 2:800, 1987.
13. Dewald GW, Dahl RJ, Spurbeck JL, et al.: Chromosomally abnormal clones and nonrandom telomeric translocation in cardiac myxomas. *Mayo Clin Proc* 62:558-567, 1987.
14. Cujec B, Ulmer B, McKaigney JP, Bharadwaj B: Right atrial myxoma presenting as Budd-Chiari syndrome. *Ann Thorac Surg* 44:658-659, 1987.
15. Morais CF, Flazoni R, Alves VA: Myocardial infarct due to a unique atrial myxoma with epithelial like cells and systemic metastasis. *Arch Pathol Lab Med* 112:185-190, 1988.
16. Bough EW, Johnson E, Zacks SI, et al.: Echocardiographic diagnosis of an infected myxoma in an atypical location. *Am Heart J* 113:1031-1032, 1987.
17. Liu HY, Panidis I, Soffer J: Echocardiographic diagnosis of intracardiac myxomas. Present status. *Chest* 84:62-67, 1983.
18. Goli VD, Thadani U, Thomas SR, et al.: Doppler echocardiographic profiles in obstructive right and left atrial myxomas. *J Am Coll Cardiol* 9:701-703, 1987.
19. Camesas AM, Lichtstein E, Kramer J: Complementary use of two-dimensional echocardiography and magnetic resonance imaging in the diagnosis of ventricular myxoma. *Am Heart J* 114:440-442, 1987.
20. Freedberg RS, Kronzon I, Rumancik WM, Liebeskin D: The contribution of magnetic resonance imaging to the evaluation of intracardiac tumors diagnosed by echocardiography. *Circulation* 77:96-103, 1988.
21. Bateman TM, Sethna DH, Whiting JS, Chaux A: Comprehensive noninvasive evaluation of left atrial myxomas using cardiac cine-computed tomography. *J Am Coll Cardiol* 9:1180-1183, 1987.

Treating Anxiety in Primary Care

KENNETH J. WEISS, MD

Anxiety disorders are a group of highly treatable problems seen in primary care. Physicians wishing to treat panic and generalized anxiety must know differential diagnoses, medications, and patient education strategies.

In 1980, psychiatrists published the first useful description of the group of mental conditions known as the anxiety disorders.¹ Since then, terms such as panic disorder, social phobia, and post-traumatic stress disorder have received enough professional and popular media coverage to render them household words. Technology such as positron-emission tomography (PET),² enhanced understanding of neurotransmitters and neuroreceptors,³ and genetic studies⁴ have legitimized the anxiety disorders as medical diseases.

The purpose of this article is to encourage clinicians to learn about anxiety disorders, to evaluate tactics in the overall strategy of anxiety reduction,

and to enter into a therapeutic collaboration with the patient. There are three important ways for the physician to achieve these goals: make a diagnosis before putting your pen to the prescription pad; consider the long-term consequences before prescribing benzodiazepines; and educate the patient about what to expect.

DIAGNOSIS FIRST

There are three broad categories of anxiety states: adjustment disorders; organic anxiety syndromes; and anxiety disorders proper (Table).

Adjustment disorders are classified as mental disorders, but fall somewhere between a reaction to stress and an illness. Examples of adjustment disorders are: nervous anticipation of performance, transitory grief over a loss or failure, and emotional crisis in medical illness. Although the patient with adjustment disorder may feel very disturbed and out of balance, almost all patients undergo a spon-

Dr. Weiss is associate professor of psychiatry, UMDNJ-Robert Wood Johnson Medical School, Camden, at Cooper Hospital/University Medical Center. Requests for reprints may be addressed to Dr. Weiss, Cooper Hospital, Department of Psychiatry, Three Cooper Plaza, Suite 403, Camden, NJ 08103.

taneous resolution in a matter of days. Hence, it is quite common for such a patient to call a physician when in such a state, only to have recovered before the day of the appointment. When the adjustment disorder is severe and has been accompanied by motor tension, agitation, insomnia, and various somatic symptoms, there may be an indication for medical intervention. The medications of choice are benzodiazepines (not barbiturates, meprobamate, or antihistamines).

The second category of anxiety states is comprised of the organic anxiety syndromes. These are states of nervous tension which have an identifiable cause, either exogenous, e.g. cocaine, or from another disease process, e.g. thyrotoxicosis. Such patients often will deny psychosocial stressors, in contrast to those with adjustment disorders. Since there is much overlap between anxiety symptoms and those of nonpsychiatric ailments, the extent of your workup will vary with your index of suspicion. Some of the more common ruleouts are thyrotoxicosis, mitral valve prolapse, and hypoglycemia.⁵ The exogenous causes of organic anxiety syndrome are prescription drugs, over-the-counter drugs, drugs of abuse, and caffeine.⁶ When taking the patient's history, it is recommended that you inquire directly about each of these, even from the elderly. Many therapeutic drugs, such as bronchodilators, steroids, decongestants, and anorexiant can cause anxiety. Caffeine, in a vulnerable person, can cause generalized and panic-type anxiety. With the widespread use of cocaine, amphetamines, and marijuana in at-risk populations, physicians must make a concerted effort to consider such agents as anxiogenic, since the treatment approach is abstinence not sedatives.

The third broad class of anxiety states is the group of anxiety disorders proper: phobic states, panic,

generalized anxiety, obsessive-compulsive disorder, and post-traumatic stress disorder. Unlike adjustment disorders, these conditions are entirely out of proportion to the perceived source of stress. Left to their own devices, patients will cope in a variety of ways, some of which can be self-destructive, as in medicating with alcohol and drugs. It cannot be overemphasized that the anxiety disorders have serious implications for health and adjustment; hence, the mandate for treatment.

Of the anxiety disorders mentioned, the most likely to present in a primary care setting are panic disorder and generalized anxiety disorder. Social phobia or performance anxiety, and its treatment with beta-blockers, was reviewed in *NEW JERSEY MEDICINE*.⁷ The phobias, obsessive-compulsive disorder and post-traumatic stress disorder, are mental illnesses requiring care from mental health specialists; they do not respond readily to simple treatment with benzodiazepine therapy.

Both panic and generalized anxiety disorders are chronic illnesses, the symptoms of which are diverse and include apprehension and dread, tension, avoidance, and symptoms of autonomic dysfunction. The major difference between the two disorders is the time course—panic disorder presents as sharp spikes of extremely intense anxiety, leading to phobic avoidance over time, whereas generalized anxiety is lower in intensity but continues over several months. In both instances, the patient is unable to account for the symptoms, which are qualitatively and quantitatively out of proportion to life circumstances.

CONSEQUENCES OF TREATMENT

Having ruled out reversible causes of anxiety and having decided that medical intervention is called for, the clinician must consider the question of treatment efficacy and side effects. The duration of clinical treatment for panic and generalized anxiety may be six months to a year or more. Options for drug therapy of panic include antidepressants, such as imipramine (Tofranil® and others) and phenelzine (Nardil®), and the benzodiazepine alprazolam (Xanax®).⁸ Choices for treatment of chronic anxiety include benzodiazepines and buspirone (BuSpar®).⁸ It must be emphasized that the optimal treatment of any mental disorder also should include psychotherapy. I tell patients that the medication will give them a "vacation" from anxiety while we work on coping skills which later may eliminate the need for medication. This certainly is true for adjustment disorder but cannot be guaranteed for more serious anxiety states.

The major pitfalls in the drug treatment of anxiety disorders are: underdosage; side effects related to sedation; and dependence and withdrawal.

Table. Anxiety states.

1. Adjustment Disorders
 - a. Reaction to stress or an illness.
2. Organic Anxiety Syndromes
 - a. Hyperthyroidism
 - b. Caffeinism
 - c. Cocaine toxicity
3. Anxiety Disorders Proper
 - a. Phobic states
 - b. Panic
 - c. Generalized anxiety
 - d. Obsessive-compulsive disorder
 - e. Post-traumatic stress disorder

Underdosage will expose the patient to side effects without giving therapeutic benefit. In the medical treatment of panic disorder, the therapeutic tactic is to block the attacks by having the patient take medication regularly. Dosage of imipramine will be 150 mg/day or more; phenelzine will be 60 mg/day. Underdosage with benzodiazepines can occur either when the clinician is fearful of the patient's becoming dependent or when the effect of the drug diminishes through tolerance. The development of tolerance should not be alarming and will not require dosage increments and a need for gradual dosage reduction at the end of therapy. All patients on benzodiazepines should be instructed never to stop their medication abruptly.

The second pitfall in anxiety therapy is the development of side effects related to sedation. These include drowsiness, impairment of thinking and memory, and adverse interaction with alcohol. These effects are most pronounced with the benzodiazepines; less with the antidepressants; and absent with buspirone. Similarly for the third pitfall, dependence and withdrawal, the benzodiazepines are highest risk, the antidepressants are a low risk, and there is no risk associated with buspirone. Any patient on long-term drug therapy, however, can become psychologically dependent on medication.

The risks associated with benzodiazepines are minimized by using these agents for as short a time as possible. Patients with a history of drug abuse, alcoholism, or self-medication should be treated by alternatives to benzodiazepine therapy, such as an antidepressant for panic or buspirone for generalized anxiety.

PATIENT EDUCATION

Successful treatment of anxiety requires informed participation on the part of the patient by the physician's clarifying the diagnosis, explaining the overall strategy of therapy, anticipating therapeutic and untoward effects, and discussing the role of psychotherapy. The following list contains some specific thoughts for physicians to use as guidelines in patient education:

1. Reassure the patient that anxiety is not a moral defect, rather an overloading of the natural danger-alerting system.

2. In most cases, the use of medication is temporary and the need for ongoing treatment will have to be shown by a trial without medication at the earliest opportunity.

3. Drug treatment of serious anxiety disorders requires regular dosing and the establishment of a therapeutic blood level of the drug. This especially is true with buspirone and antidepressants, which cannot be used on an as-needed (PRN) basis.

4. Anxious persons should avoid caffeine and other stimulants.

5. Alcohol, especially with benzodiazepines, is not a medication and should be avoided.

6. Even though you have told the patient not to stop medication abruptly, a word should be said about the meaning of withdrawal. Patients undergoing benzodiazepine withdrawal find it frightening and erroneously will assume they need medication permanently.

7. If one medication must be stopped because of side effects or lack of effect, the patient should be reassured that there are alternatives. The physician's attitude toward the illness and treatment is a major factor in outcome.

CONCLUSION

Anxiety disorders are bona fide illnesses that are common and highly treatable. In a primary care setting, identifying patients with adjustment problems, organic anxiety syndromes, or anxiety disorders proper is the first step in formulating a treatment strategy. Specific tactics include using drugs with high efficacy and low side-effect profiles, minimizing long-term consequences, and educating patients adequately. Collaborating with a mental health professional, at least in the form of a psychiatric consultation, also will aid in the patient's management. Early and appropriate treatment of anxiety will reduce secondary morbidity, cut unnecessary office visits to physicians, and enable the patient to develop a long-term ability to cope with life. ■

REFERENCES

1. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition. Washington, DC, American Psychiatric Association, 1980.
2. Reiman EM: The quest to establish the neural substrates of anxiety. *Psychiatr Clin North Am* 1:295-307, 1988.
3. Teicher MH: Biology of anxiety. *Med Clin North Am* 72:791-814, 1988.
4. Noyes R, Clarkson C, Crowe RR, et al.: A family study of generalized anxiety disorder. *Am J Psychiatry* 144:1019-1024, 1987.
5. Raj A, Sheehan DV: Medical evaluation of panic attacks. *J Clin Psychiatry* 48:309-313, 1987.
6. Weiss KJ: The interrelationships between anxiety, alcoholism, and drug addiction, in: Noyes R, Roth M, Burrows GD (eds): *Handbook of Anxiety, Volume 2*. Amsterdam, Elsevier Science Publishers, 1988, pp. 365-397.
7. Lehrer PM, Rosen RC, Kostis JB, et al.: Treating stage fright in musicians: The use of beta-blockers. *NJ MED* 84:27-33, 1987.
8. Roy-Byrne PP, Katon W: An update on treatment of the anxiety disorders. *Hosp Community Psychiatry* 38:835-843, 1987.

The big difference between your retirement plan and AMA Advisers plan is the fees...

We have none.

Compare your present retirement plan to the "No fee" plans offered by AMA Advisers, Inc., and see the many money-saving advantages we offer.

- No charge to open or rollover to an AMA Advisers plan
- No account set-up fees
- No maintenance fees
- No charge for plan amendments to comply with changing IRS laws

Whether you have a retirement plan right now or not, mail the coupon below or call AMA

Advisers, Inc. to see how much money you'll save with us on fees and services.

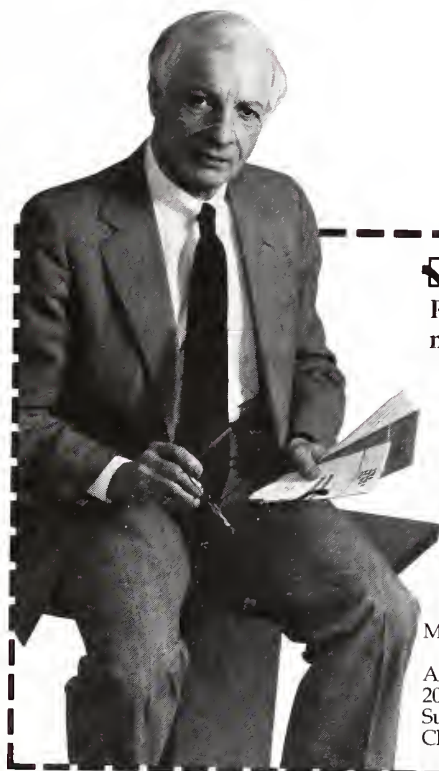
AMA Advisers, Inc., the Financial Services and Investment Counseling Organization owned by the American Medical Association, has been helping physicians and their families reach retirement goals for 23 years. And we'd like to help you.

Call toll-free today and compare. Or mail the coupon below.

1-800-523-0864

(In PA call collect
(215) 825-0400)

Serving the investment needs of
physicians and their families since 1966.



☒ **YES!** I want to know how much money the "No-fee" Retirement Plans offered by AMA Advisers, Inc. will save me. I understand I am under no obligation whatsoever.

Name _____

Address _____

City _____ State _____ Zip _____

Phone: () _____ Birth Date _____

Year In Which You Plan to Retire _____

Mail this coupon to:

AMA Advisers, Inc.
200 N. LaSalle Street
Suite 535
Chicago, IL 60664-1910

AMA ADVISERS, INC.
The Financial Services and Investment
Counseling Organization Owned by
the American Medical Association

Established in 1966



RPNFNJ

State Programs for the Elderly

ANTHONY M. VILLANE, JR, DDS

The Department of Community Affairs, established in 1967, helps local governments take advantage of various programs and services available to them from both the state and federal governments. Programs in New Jersey will benefit our elderly citizens.

As a practicing dentist for 30 years, I know the faith and trust older people place in the medical professionals who administer to them. However, it wasn't until I became community affairs commissioner that I learned about the many benefits New Jersey provides for its older people. The Department of Community Affairs was established in 1967 to help local governments take advantage of the various programs and services available to them from both the state and federal governments. The Department's divisions—Aging, Local Government Services, Housing and Development, Community Resources, and Women—complement each other, enabling the Department to help improve the quality of life for New Jersey's residents. However, it is the Division on Aging which serves as the central agency for the planning and coordination of programs, services, and benefits for the state's older citizens.

We all know that as people grow older their needs increase. Therefore, it is very important that physicians be aware of the programs and benefits available to them. Many senior citizens do not know about these services despite our efforts to advise them. I would like to bring to your attention some of the programs available in New Jersey.

1. Senior Citizens Information and Referral

Mr. Villane is Commissioner of the New Jersey State Department of Community Affairs. Requests for information and reprints may be addressed to Commissioner Villane, New Jersey Department of Community Affairs, William Shady Community Affairs Building, 101 South Broad Street, CN 800, Trenton, NJ 08625-0800.

Service. This is a toll-free hotline operated by experts within the Division on Aging. The hotline is a source of information on local, state, and federal programs for the elderly. It operates from 9 A.M. to 5 P.M. daily, except on state holidays. Call this hotline number for information about local, state, or federal programs, publications, and benefits for persons over age 55. Post this toll-free number—1/800/792-8820—in your office or hospital so you or your staff can call for information whenever you have a question about the various programs for the aging. Posters and brochures are available free from the Division on Aging, Department of Community Affairs, 101 South Broad Street, Trenton, NJ 08625.

2. Noon-time Nutrition Programs. The Division also funds nutrition programs in more than 250 municipalities in New Jersey. Nutrition programs provide seniors with a nutritious hot midday meal, as well as an opportunity to get together with friends. In addition, staff members at these sites look for signs of problems and often refer seniors to the appropriate agency for help. Some centers regularly offer blood pressure clinics. For many seniors, the relationships that have developed and the programs provided at these nutrition sites have meant the difference between leading a full life and sitting home alone and unhappy. Meals also can be provided for the frail homebound elderly. Information about this service is available by phoning the hotline number or the nearest area agency on aging, usually located in the county seat.

3. Publications. "Statewide Benefits for Older Persons" and "Federal Programs for Older Persons" are brochures listing programs for older people. Both

publications are available free of charge.

4. PAAD. The Pharmaceutical Assistance to the Aged and Disabled (PAAD) program provides prescription payments for older people. Eligible seniors pay \$2 for any prescription; the state pays the balance. To qualify, a person must have been a state resident for at least 30 days, have no coverage by a private prescription plan, have an income less than \$13,650 if single or \$16,750 if married, be 65 years of age or older or receiving Social Security disability benefits. Undoubtedly, there are many older people who qualify for PAAD who do not know of its existence. Explanation of this program by your office staff members to people who need such services would be extremely helpful.

There also is a hearing aid assistance program for people who do not qualify for Medicaid, but who meet the age, disability, income, and residency requirements of PAAD.

5. The Community Care Program. This program for the elderly and disabled is available under a special Medicaid waiver. The New Jersey Medicaid Program offers services to help eligible individuals who wish to remain in their homes, rather than go into a nursing home. To be eligible, one must be 65 or older, disabled, not receiving Medicaid services in the community, or in need of nursing home care but preferring to remain at home. There is an income eligibility requirement.

6. Personal Attendant Services Program. New Jersey residents ages 18 to 65 having a chronic physical disability may be eligible to participate in this program. It provides patients with 10 to 40 hours per week of personal attendant services to assist in their essential daily activities and enable them to remain independent within the community. Priority is given to those who are employed or preparing for employment. Services include assistance with bathing, dressing, meal preparation, laundry, shopping, driving, and transportation. Designed to help people who have no one to care for them, the program currently operates in 13 counties that have an Office of the Handicapped. It will be expanded into the remaining eight counties.

7. Statewide Respite Care Program. New Jersey established the Statewide Respite Care Program to assist families with the care of their elderly and functionally impaired family members. Eligibility is based on income resources, and need for services.

8. Congregate Housing Services. The Division on Aging contracts with numerous subsidized housing projects throughout the state to provide a support program for low-income frail elderly people. The Congregate Housing Services Program provides one or two meals a day in a group setting, personal care services, including assistance with dressing,

bathing, hairwashing, shopping, and escorting also helps with housekeeping. The costs to participants are based on income.

9. Legal and Other Services. All counties through legal service providers funded by the state agencies on aging, provide free legal services to older people without regard to income. Elderly people who suffer abuse from caregivers or relatives may participate in the Adult Intervention Program which provides emergency shelter, heat, medical care, food, clothing, and many other services, including protection from financial and personal exploitation.

10. Additional Programs. Did you know that disabled veterans are entitled to 100 percent of estate tax exemptions? Or that various licenses such as real estate, insurance, and brokerage, are available at no charge to these veterans? Did you know senior citizens, 62 and older, and handicapped people, also are eligible for half the regular one-way fare on all intrastate bus and rail routes and on interstate bus and rail routes into adjacent states? Elderly or handicapped people must present a valid Medicare card or a Reduced Fare Program identification card upon boarding a bus or train. Applications for a reduced fare card can be made at a local bank, savings and loan institution, or at an agency of aging by presenting a social security card and proof of age. Did you know the state also sponsors the Lifeline Credit Program for utility assistance? If some of your patients have a difficulty time paying for gas or electricity, they may qualify for this assistance. The plan offers a benefit of \$2 to those 65 and older and to certain disabled people who are receiving Social Security disability payments. Did you know under New Jersey law, grandparents have the right to visit with their minor grandchildren in the event one or both parents are dead, separated, or divorced? Did you know no state, county, or municipal government entity may discriminate against job applicants because they have reached the age of 40? Further, no employer may refuse to hire, employ, bar, or discharge individuals from employment due to age. However, there is nothing in the law to prevent an employer from refusing to accept for employment, or to promote any person over 70. Did you know that a resident of New Jersey who is 70 or older can get a fishing license free?

CONCLUSION

If you would like more information about programs for New Jersey residents, young and old alike, you may call me at 609/292-6420. I also urge you to contact our Division on Aging for its booklets on programs for the elderly. I am certain many of your patients could and would avail themselves of these services if they knew about them. ■

Resection of Proximal Bile Duct Cancer

Involving Hepatic Artery with Five-Year Survival

BERNARD GARDNER, MD

A case of primary bile duct cancer encasing the hepatic artery is presented. Resection of the tumor and involved duodenum with postoperative radiotherapy was followed by a five-year survival with no evidence of disease.

In 1965, Klatskin¹ reported 13 cases of carcinoma at the confluence of the right and left hepatic ducts; a classification of these tumors was made by Bismuth in 1975.² None of the original tumors was resected, but since then, increasing numbers of patients have been resected with the realization of five-year survivals in a small percentage of patients. Diagnosis now can be made with increasing accuracy due to the introduction of transhepatic cholangiography in patients with dilated intrahepatic ducts. Angiography is helpful in assessing the extent of involvement and it has been stated that preoperative angiography demonstrating hepatic ar-

tery involvement rendered the patient unresectable.³ This case report demonstrates that resection still is possible under these circumstances, leading to prolonged survival.

CASE REPORT

A 76-year-old white female with jaundice of 2 weeks' duration was admitted on January 30, 1983. Preoperative laboratory values showed: normal white blood count and hematocrit; bilirubin of 10.9 mgm% (normal 0.6-1.0 mgm%); alkaline phosphatase of 82 units (normal < 59 units); albumin of 2 gm% (normal 3.5-5.6 gm%); globulin of 3.3 gm% (normal 1.5-3.5 gm%); and, SGOT of 49 units (normal < 40 units). A sonogram showed a pancreatic mass.

An operation was performed on February 1, 1983.

Dr. Gardner is affiliated with the Department of Surgery, Hackensack Medical Center. Requests for reprints may be addressed to Dr. Gardner, Hackensack Medical Center, 30 Prospect Avenue, Hackensack, NJ 07601.

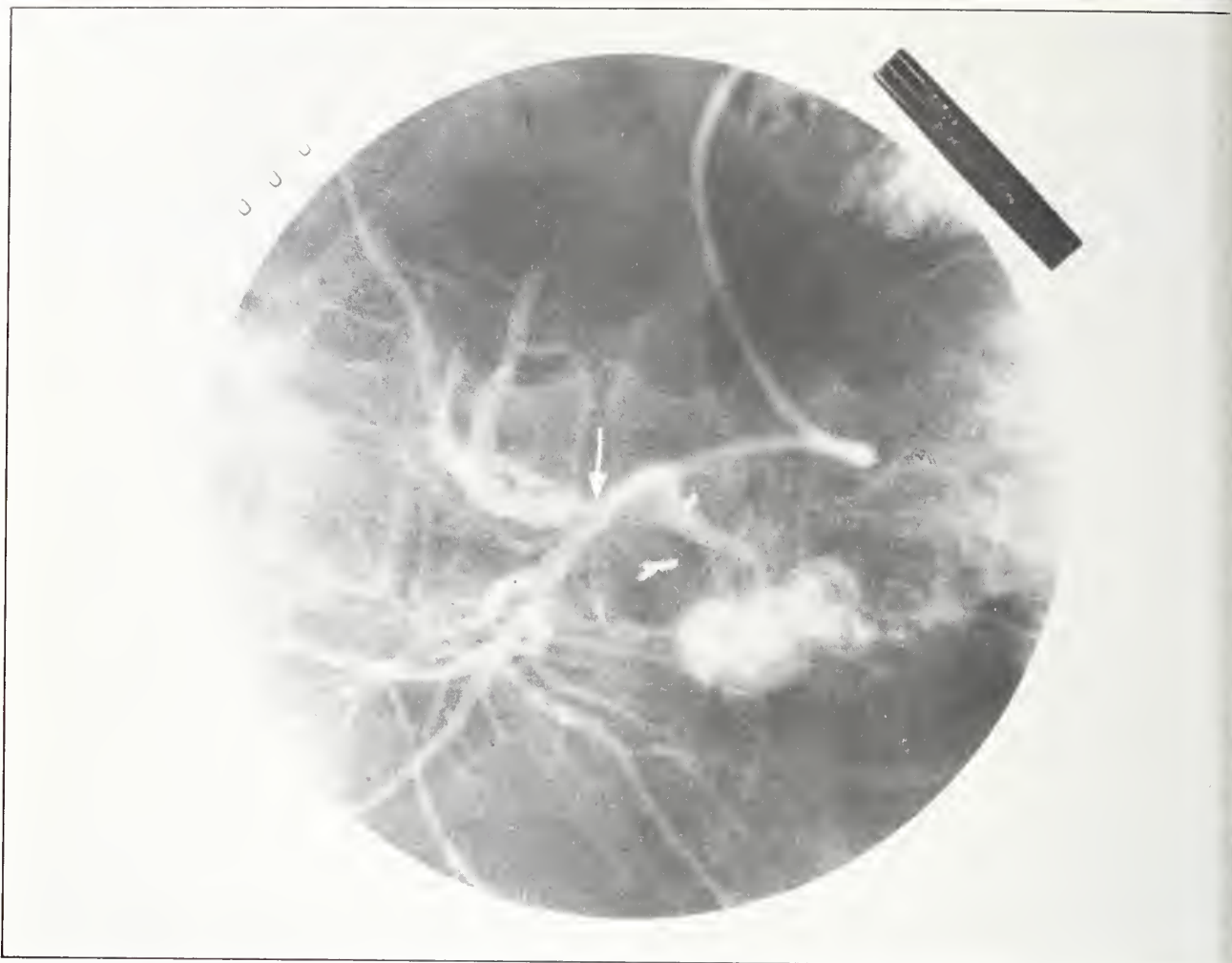


Figure 1. T-tube cholangiogram showing narrowing at the bifurcation of the common hepatic duct (arrow).

A 3 x 5 cm porta hepatis mass and a large calcific gallbladder was present; no mass was present in the pancreas. The common hepatic duct was entered, a T-tube was placed, and a biopsy taken. A cholecystostomy was made to drain the gallbladder. The postoperative course was uneventful.

A postoperative cholangiogram (Figure 1) demonstrated narrowing at the confluence of the hepatic ducts. The patient was discharged on February 12, 1983. Since the surgeon considered the procedure palliative, the patient was discharged with the T-tube and cholecystostomy tube in place. No further treatment was contemplated. Pathology of the duct biopsy showed well-differentiated adenocarcinoma.

Readmission was made on August 2, 1983. The patient had recurrent jaundice and bloody drainage from the T-tube. The cholecystostomy tube had been removed as an outpatient. A hard mass was palpated in the right upper quadrant.

Laboratory results were bilirubin, 23.0 mgm% (normal 0.6-1.0 mgm%); alkaline phosphatase, 412 units (normal < 59 units); and SGOT, 119 units (normal < 40 units).

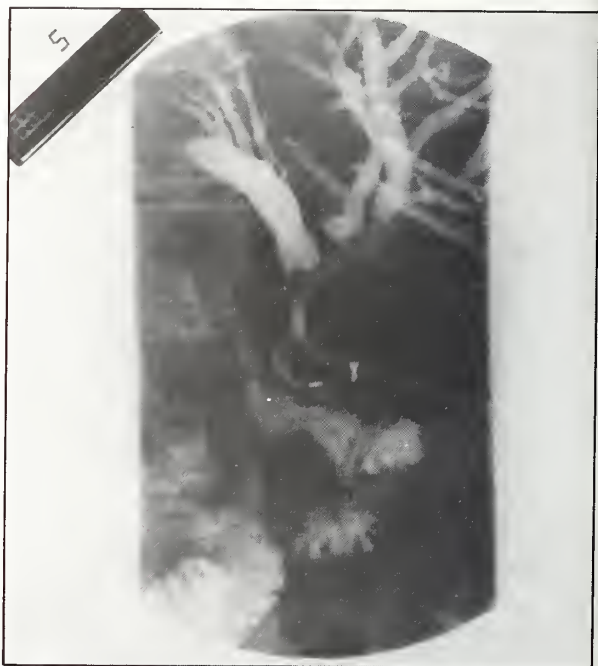


Figure 2. T-tube cholangiogram some months later showing almost complete obstruction of the common hepatic duct with a trickle of dye entering the duodenum.

CASE REPORT

A T-tube cholangiogram showed dilated radicals. The right hepatic duct was not well visualized with almost complete obstruction of the common hepatic duct (Figure 2), but with some trickling of dye into the duodenum. A liver scan was negative and an arteriogram demonstrated encasement of the right hepatic artery and portal vein compression (Figure 3). An operation was performed on August 12, 1983, and revealed a mass present in the porta hepatis. The duodenum was trapped in the tumor mass and the duodenum and gallbladder were dissected with the mass. The pancreas was free. The common bile duct was transected and the distal end oversewn. The duct tumor and associated organs were dissected off the portal vein up to the bifurcation of the hepatic ducts beyond the mass. The hepatic artery was identified and freed from the mass.

After resection, a Roux-en-Y loop of jejunum was anastomosed to each of the hepatic ducts and a gastroduodenostomy was used to restore gastrointestinal continuity.

Postoperatively, the patient had no complications and was discharged 14 days later. Radiotherapy was given, as 4,500 rads to the porta hepatis using anterior and posterior fields.

The patient was last seen in December 1988, almost six years from the initial operation; she appeared in good health with a normal bilirubin and alkaline phosphatase.

DISCUSSION

This case is important because it demonstrates resection can be successful when the tumor is not removed at initial operation and it is not precluded by angiographic demonstration of hepatic artery involvement. Hepatic lobectomy with tumor resection is feasible in some cases of arterial involvement. The preoperative angiogram is valuable to demonstrate the anatomy of the hepatic circulation. Reports clearly indicate that resection offers the only chance of cure and is far superior to intubation of the ducts for palliation.^{4,6} The role of radiotherapy is not clear in the management of this disease^{5,7} but was recommended in this case because of the proximity of the major hepatic vasculature and uncertainty about the adequacy of the margins. It may have

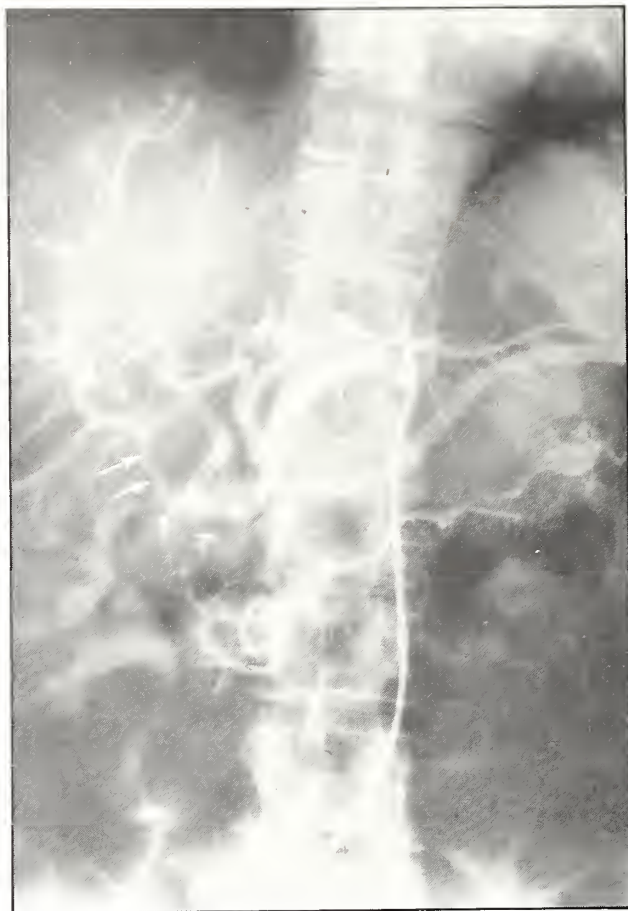


Figure 3. Celiac arteriogram demonstrating encasement of the right hepatic artery (arrows) and portal vein compression for our patient.

contributed to survival and we recommend its use in similar cases.

SUMMARY

A 76-year-old woman, with type 1 (Bismuth) common hepatic duct cancer, had a previous intubation of the tumor which was considered unresectable. After six months, a preoperative angiogram showed hepatic artery involvement. Despite these negative factors, resection with attached duodenum and gallbladder was successfully carried out. Postoperative radiotherapy was given. A five-year survival was achieved, and the patient currently is free of symptoms. ■

REFERENCES

1. Klatskin, G: Adenocarcinoma of the hepatic duct at its bifurcation within the porta hepatis. *Am J Med* 38:241, 1965.
2. Bismuth H, Corlette MB: Intrahepatic cholangioenteric anastomosis in carcinoma of the hilus of the liver. *Surg Gynecol Obstet* 140:170, 1975.
3. Evander A, Fredlund P, Haevels J, et al.: Evaluation of aggressive surgery for carcinoma of the extrahepatic bile ducts. *Am Surg* 191:23, 1980.
4. Adkins RB Jr, Dunbar LL, McKnight WG, Farringer JL Jr: An aggressive surgical approach to bile duct cancer. *Am Surg* 52:134, 1986.
5. Langer JC, Langer B, Taylor BR, et al.: Carcinoma of the extrahepatic bile ducts: Results of an aggressive surgical approach. *Surgery* 98:752, 1985.
6. Alexander F, Ross RL, O'Bryan M, et al.: Biliary carcinoma. *Am J Surg* 147:503, 1984.
7. Molt P, Hopfan S, Watson RC, et al.: Intraluminal radiation therapy in the management of malignant biliary obstruction. *Cancer* 57:536, 1986.

Early Stage Pure Seminoma Testis

ANDREW ZABLOW, MD
PAUL ERBA, MD
LOUIS J. SANFILIPPO, MD

Forty-three patients with early stage pure seminoma of the testis were analyzed retrospectively. All patients were treated with orchiectomy and radiation therapy. Overall survival was 97.7 percent, with followup ranging from 4.3 to 17.4 years.

There will be approximately 5,700 new cases of testicular carcinomas in the United States this year. Approximately 40 percent of these carcinomas will be reported as seminoma.¹ Seventy to 75 percent of these carcinomas will be early stage disease that are highly radiosensitive and radio-curable.² The tumor is most common in young men in their third and fourth decades when they have many potential years of productivity. This study summarizes our experience.

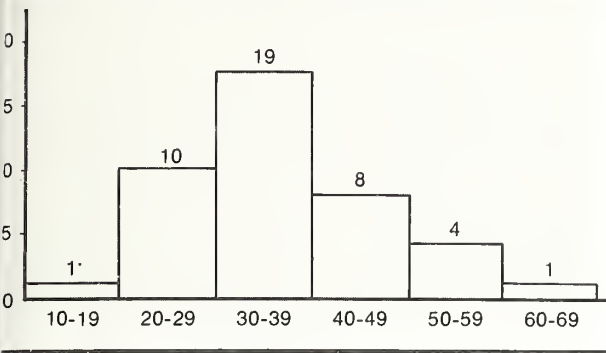
MATERIALS AND METHODS

The records of 53 patients who underwent radiotherapy (RT) at Saint Barnabas Medical Center for

testicular neoplasms from 1970 to 1984 were reviewed. Forty-five patients were found to have pure seminoma, five patients had mixed histology including seminoma, embryonal, teratocarcinoma, and/choriocarcinoma; two patients had lymphoma; and one patient had a paratesticular rhabdomyosarcoma. Of the 45 pure seminoma patients, 2 patients were stage IV. One patient was metastatic to bone and the other patient was metastatic to the liver. Both patients were excluded from the study. The remaining 43 patients with early stage pure seminoma form the basis of this study. The ages of the patients ranged from 19 to 60 years with a median age of 34. The age distribution is shown in Table 1. There were 44 testicular seminomas among the 45 patients. There were 21 unilateral malignancies on both the left and right sides, respectively. One patient had bilateral involvement. Eight patients had a history of unilateral cryptorchidism and one patient had bilateral cryptorchidism. One patient had a previous seminoma treated with orchiectomy and radiotherapy at another hospital nine years before

Dr. Zablow is attending and Dr. Sanfilippo is chairman, Department of Radiation Oncology, Saint Barnabas Medical Center, Livingston. Dr. Erba is attending radiation oncologist, St. Mary's Hospital, Enid, Oklahoma. Requests for reprints may be addressed to Dr. Zablow, Saint Barnabas Medical Center, Department of Radiation Oncology, Livingston, NJ 07039.

Table 1. Age distribution, seminoma testis.



receiving treatment at our institution. Pathology revealed 36 patients (87 percent) with pure (classical) seminoma, 6 patients (14 percent) with anaplastic seminoma, and 1 patient (2 percent) with spermatocytic seminoma (Table 2). Thirty-three patients had tumor limited to the body of the testis and 10 patients had localized extension involving the tunica, epididymis, rete testis, and/or cord.

Workup of patients consisted of a complete history and physical, routine blood studies, serum alpha-fetoprotein and computed tomography (CT), beta-human chorionic gonadotropin (HCG), chest x-ray, intravenous pyelogram (IVP), bipedal lymphangiography, and/or abdominal-pelvic CT scanning.

The staging system used was a modification of the Walter Reed Staging System:^{3,4} Stage I—Tumor confined to the testis, cord, or covering. Stage II—Tumor confined to testis, cord, or covering with positive retroperitoneal lymph node disease below the diaphragm. Stage IIA—X-ray evidence of LN+, no palpable abdominal mass. Stage IIB—Same as for IIA, but with palpable abdominal mass. Stage III—Supradiaphragmatic lymph node spread to mediastinum, supraclavicular nodes, or both. Stage IIIA—No palpable abdominal mass. Stage IIIB—Palpable abdominal mass. Stage IV—Visceral metastatic disease (i.e. liver, bone, or lung).

There were 31 (72 percent) patients and 12 (28 percent) patients in stage I and stage IIA, respectively. Following inguinal orchiectomy (1 patient had bilateral orchiectomy), all patients received post-operative radiotherapy using either a 6 or 10 MeV linear accelerator at 100 cm SSD. Twenty-one stage I patients were treated with AP-PA opposed inverted "Y" fields. The treatment volume encompassed the bilateral inguinal and iliac nodes and the bilateral periaortic nodes. Extended ilioinguinal fields were added to the ipsilateral side of the 10 patients who had tumor involvement of the tunica, epididymis, and/or spermatic cord. Following a treatment policy change in 1981, 5 patients were treated with a modified inverted "Y" or "dog-leg" port that encompassed the ipsilateral inguinal and iliac nodes and the bilateral periaortic nodes. Patients were treated

Table 2. Histology by stage.

	Stage I	Stage II	Total
Classical seminoma	25	11	36
Anaplastic	5	1	6
Spermatocytic	1	0	1
Total	31	12	43

with 150 cGy daily fractions to a total midline tumor dose of between 3000-3460 cGy.

Twenty-nine of 31 stage I patients received no additional treatment after infradiaphragmatic RT. Two patients received prophylactic mediastinal/neck irradiation (PMI) during the early part of the time period examined. All 12 stage IIA patients received 3000 cGy with the inverted "Y" portal and 6 patients received a booster dose of 600 to 1050 cGy to involved periaortic adenopathy as indicated by the lymphangiogram or CT scan. Following a four-to six-week rest period, 9 of 12 patients received elective PMI consisting of 2700 to 3000 cGy. The field encompassed the mediastinum and supra-clavicular lymph nodes.

RESULTS

In our series of 43 patients, there were no treatment failures. Followup ranged from 4.3 to 17.4 years with a median of 11.3 years. The overall survival rate for the entire group was 97.7 percent. One patient died of intercurrent disease and there was no evidence of disease almost 16 years after treatment. Another patient developed a stage D adenocarcinoma of the colon, his third primary malignancy, 14 years after treatment. He had surgery and presently is receiving chemotherapy for known liver and bone metastasis. There is no evidence of recurrent seminoma.

Most patients developed transient acute toxicity from retroperitoneal radiation. This most commonly consisted of mild nausea with occasional vomiting that was well controlled with antiemetic medication. Other side effects of fatigue, abdominal cramping, and hematopoietic depression were self-limiting and resolved soon after completion of treatment. A few patients who received PMI developed mild symptoms of esophagitis. No late complications from treatment were seen.

DISCUSSION

To date, with a minimum followup of 4.3 years, there have been no local or distant treatment failures. In accordance with previously published reports, our entire patient population has passed a two-year followup period, the time at which the majority of relapses are seen.^{5,8}

The extremely high cure rates for early stage seminoma treated by orchiectomy and radiotherapy were reproduced in our series. Our overall actuarial survival (Kaplan-Meier method) is 100 percent at 5, 10, and 15 years. This, of course, compares very well with other large series summarized in Table 3.

The question of PMI for patients with stage II disease remains a controversial issue. Thomas and colleagues at Princess Margaret Hospital, Toronto, feel that PMI can be omitted for stage II as salvage therapy yields excellent results with external radiotherapy or chemotherapy.¹² Hanks reported the findings of the Patterns of Care Study and stated that PMI had little morbidity and prevented supradiaphragmatic relapse.¹³ They recommended its use in treating stage II disease. We currently are giving infradiaphragmatic radiotherapy for early stage IIA disease and advocate PMI for borderline stage IIA-IIB disease. Due to the high cure rate in stage IIA disease, other large centers are withholding PMI and have adopted a surveillance program for supradiaphragmatic relapse.^{6,9,14,15}

Maintenance of sexual function and fertility after curative radiotherapy is an important issue to the cancer patient. In the last few years, we have been asking our patients who desire progeny in later years to undergo a pre-irradiation semen analysis. Most of the young men have been found to have oligospermia and a few were azoospermic. In addition, there were aberrations of spermatic motility and morphology. This is suggestive that the tumor has some influence on spermatogenesis.¹⁶ Studies have found that 50 to 79 percent of patients have abnormally low sperm counts after unilateral orchiectomy but before radiation treatment.^{17,18} Careful attention is paid to field shape and blocking, to minimize the radiation dose to the contralateral testicle. The opposite testis is kept outside the radiation portal but it has been shown that the gonadal dose is due to intra-ab-

dominal scattered radiation rather than direct irradiation. Rowley showed that single doses of 20 cGy caused decreases in sperm counts and concomitant elevation of follicle-stimulating hormone (FSH). He found a dose to time relationship for complete recovery of sperm counts. For those receiving less than 100 cGy, recovery was complete in 9 to 18 months, 30 months for doses of 200 to 300 cGy, and 60 or more months for doses of 400 to 600 cGy. Other authors have found spermatogenesis recovery to be dose dependent up to approximately 160 cGy.²⁰ Redrick calculated gonadal doses of 28 to 135 cGy in male patients with Hodgkin's disease who were treated with a full inverted "Y" port to 3750 to 4500 cGy using special gonadal shielding.²² Also, 88 percent were fertile when tested 26 months after treatment. For the large percentage of men with low pretreatment seminal parameters, cryopreservation does not appear to be a feasible means of maintaining fertility.²² Fertility is dependent upon normalizing testicular function after curative irradiation. This illustrates the importance of the staging workup and meticulous treatment planning. Pre-treatment counseling on infertility and sexual function should be offered to all patients.

Thorough staging mandates that the pelvic retroperitoneal, mediastinal, and supraclavicular lymph nodes be evaluated for metastases. Seminomas have an orderly lymphatic spread and early hematogenous spread rarely is seen. Approximately 15 to 20 percent of patients with clinical stage I disease will have lymph node metastasis. The development of reliable radiographic techniques, including CT and lymphography, have obviated the need for surgical staging. Anatomical descriptions of lymphatic drainage of the testes are well described.

We believe that lymphangiogram (LAG) and CT are essential, complementary studies in evaluating patients for metastases and for treatment planning.

Table 3. Five-year survivals for early stage pure seminoma testis treated with orchiectomy and radiotherapy.

Series	Stage I		Stage II*	
	Patients	Survival (%)	Patients	Survival (%)
Zagars, et al., 1986 ⁵	163	95 ⁺	62	90 ⁺
Epstein, et al., 1987 ⁹	42 ⁺	100 ⁺	16	100 ⁺
Andrews, et al., 1987 ⁸	30	93 ⁺	21	100 ⁺
Lester, et al., 1986 ⁶	33	91 ⁺	15	80 ⁺
VanderWerf-Messing, 1976 ¹⁰	58	100	74	75
Dosoretz, et al., 1981 ¹¹	135	97	25	92
Saint Barnabas Medical Center, 1988	31	100 ⁺	12	100 ⁺
Total	492	97%	225	87%

*Each series includes some stage IIB patients except the series from Saint Barnabas Medical Center.

⁺Corrected for intercurrent disease.

we suggest that after orchiectomy all patients initially be evaluated with an abdominopelvic CT scan. This is a noninvasive examination that yields an overall accuracy approaching 90 percent with false negatives and false positives averaging 10 percent and less than 5 percent, respectively.²⁴ These results were obtained primarily on nonseminomatous tumors that were evaluated either at surgery or at autopsy that permitted histopathological correlation. CT is advantageous in that it can better examine the retroperitoneal nodal areas proximal to the cisterna chyli and delineate any extension to adjacent organs. The disadvantages of CT are its inability to delineate intranodal architecture and its use of nodal size for determining abnormality. Nodes greater than 1 cm are considered suspicious and greater than 1.5 cm are considered abnormal. If the CT findings are positive, we plan our treatment accordingly. For negative or equivocal results, we recommend LAG. Nodal metastases from seminomas produce several changes in the architectural structure of the involved nodes that are well recognized on LAG. These include causing the nodes to be more spherical than normal and exhibit a crescent-shaped

deformity. The overall accuracy of LAG is similar to that of CT. Both studies are important to help the radiation oncologist delineate the location and extent of disease and accurately localize the treatment portals. Contrast material is retained by the lymph nodes permitting post-treatment evaluation by abdominal roentgenograms.

CONCLUSION

Orchiectomy and postoperative radiation therapy are highly effective treatment for patients with stages I and IIA pure seminoma testis. Survival rates approximating 100 percent are commonly seen. Lymphangiogram and abdominopelvic CT are important compatible procedures utilized for accurate staging and treatment planning. No late complications were seen. Proper attention must be given to treatment details. PMI can be withheld in patients with early stage disease. Patients should be followed closely for the first two years and periodically thereafter.

It appears that every patient presenting with early stage seminoma testes is potentially curable when effective treatment is provided. ■

REFERENCES

1. Silverberg E, Lubera JA: Cancer statistics. *CA* 9:3-20, 1989.
2. DeVita VT, Hellman S, Rosenberg SA (eds): *Cancer, Principles and Practice of Oncology*. Philadelphia, PA, J.B. Lippincott Co, 1985, pp. 979-1011.
3. Maier JG, Sulak MH: Radiation therapy in malignant testis tumors. Part I: Seminoma. *Cancer* 2:1212-1216, 1973.
4. Doornbos JF, Hussey DH, Johnson DF: Radiotherapy for pure seminoma of the testis. *Radiology* 16:404-408, 1975.
5. Zagars GK, Babaian RJ: Stage I testicular seminoma: Rationale for postorchiectomy radiation therapy. *Int J Radiat Oncol Biol Phys* 13:155-162, 1987.
6. Lester SG, Morphis JG, Hornback NB: Testicular seminomas: Analysis of treatment results and failures. *Int J Radiat Oncol Biol Phys* 12:353-358, 1986.
7. Hamilton C, Horwich A, Easton D, Peckham MJ: Radiotherapy for stage I seminoma testis: Results of treatment and complications. *Radiother Oncol* 6:115-120, 1986.
8. Andrews CF, Micaily B, Brady LW: Testicular seminoma: Results of a program of megavoltage irradiation. *Am J Clin Oncol* 10(6):491-495, 1987.
9. Epstein GE, Zinreich ES, Order SE: Staging, treatment, and results in testicular seminomas: A 12-year report. *Int J Radiat Oncol Biol Phys* 15:131, 1988.
10. VanderWerf-Messing B: Radiotherapeutic management of testicular tumors. *Int J Radiat Oncol Biol Phys* 1:235-248, 1976.
11. Dosoretz DE, Shipley WU, Blitzer PH, et al.: Megavoltage irradiation for pure testicular seminoma: Results and patterns of failure. *Cancer* 48:2184-2190, 1981.
12. Thomas GM, Rider WD, Dembo AJ, et al.: Seminoma of the testis: Results of treatment and patterns of failure after radiotherapy. *Int J Radiat Oncol Biol Phys* 8:165-174, 1982.
13. Hanks GE, Herring DF, Kramer S: Patterns of care, outcome, studies: Results of the national practice in seminoma of the testis. *Int J Radiat Oncol Biol Phys* 7:1413-1417, 1981.
14. Ball D, Barrett A, Peckham MJ: The management of metastatic seminoma testis. *Cancer* 50:2289, 1982.
15. Zagars GK, Babaian RJ: The role of radiation in stage II testicular seminoma. *Int J Radiat Oncol Biol Phys* 13:163-170, 1987.
16. Fossa SD, Abyholm T, Aakvaag A: Spermatogenesis and hormonal status after orchiectomy for cancer and before supplementary treatment. *Eur Urol* 39:68, 1983.
17. Berthelson JG: Sperm counts and serum follicle-stimulating hormone levels before and after radiotherapy and chemotherapy in men with testicular germ cell cancer. *Fertil Steril* 44:281, 1984.
18. Hendry WF, et al.: Semen analysis in testicular cancer and Hodgkin's disease: Pre and post-treatment findings and implications for cryopreservation. *Br J Urol* 55:769-773, 1983.
19. Rowley MJ, Lack DR, Warner GH, Heller CG: Effects of graded doses of ionizing radiation on the human testis. *Radiat Res* 59:665-678, 1974.
20. Freund I, Zenzen MT, Muller RP, et al.: Testicular function in eight men with seminoma after unilateral orchiectomy and radiotherapy. *Int J Androl* 10:447-455, 1987.
21. Hahn EW, Feingold SM, Simpson L, Batata M: Recovery from aspermia induced by low-dose radiation in seminoma patients. *Cancer* 50:337-340, 1982.
22. Pedrick TJ, Hoppe RT: Recovery of spermatogenesis following pelvic irradiation for Hodgkin's disease. *Int J Radiat Oncol Biol Phys* 12:117-121, 1986.
23. Bracken RB, Smith KC: Is semen cryopreservation helpful in testicular cancer? *Urology* 15:581-583, 1980.
24. Clouse ME, Wallace S: *Lymphatic Imaging, 2nd Edition*. Baltimore, MD, Williams & Wilkins, 1989, pp. 348-368.

NOTEBOOK

UMDNJ NOTES

An innovative bone marrow transplantation procedure to treat certain cancers is being provided in a new joint program of the University of Medicine and Dentistry of New Jersey (UMDNJ) and St. Peter's Medical Center, New Brunswick. The program, based at the hospital, is directed by the Division of Hematology and Oncology at UMDNJ-Robert Wood Johnson Medical School, New Brunswick.

The procedure involves removing a small portion of the patient's bone marrow to protect it from the high doses of chemotherapy needed to destroy cancer cells, and then returning the marrow after the patient is treated. This approach is used for several forms of cancer, including Hodgkin's disease, other lymphomas, breast and ovarian cancer, and certain brain tumors.

The best candidates for the procedure are those patients who are otherwise in good health, who can tolerate massive doses of chemotherapy, and who have tumors that have responded to standard chemotherapy.

The program is part of a regional bone marrow consortium that also includes the University of Connecticut; Westchester County Medical Center/New York Medical College; and North Shore University Hospital, Long Island, New York. The group studies a broad spectrum of patients to devise optimum drug combinations.

UMDNJ researchers have developed a computerized three-dimensional video-imaging system

that greatly enhances precision in orthodontic work and oral surgery. The researchers, who combined dentistry and biomedical engineering, have received a patent on the system from the U.S. Patent Office. The imaging system, which allows dentists to measure more precisely soft tissues of the face, was developed by the Dental Diagnostic Systems Laboratory at the UMDNJ-New Jersey Dental School.

Using a sophisticated technique called structured light, a video camera records images of six different angles of the face. At each angle, a grid of horizontal and vertical lines is placed in front of the light source illuminating the face. The grids appear on the pictures taken at each angle and are used to measure the contours of the face. Each picture is fed into a computer processor, which combines all six pictures to produce a composite, three-dimensional photograph that details the contours of the face.

Using these precise pictures to make measurements, dentists can plan oral surgery, orthodontic work, and plastic surgery. The system also can be used to make dentures and replacement parts for the face after traumatic accidents or disfiguring cancer surgery.

The system also is being used to measure the area of skin grafts for burn victims at the burn center at St. Barnabas Hospital, Livingston, a UMDNJ affiliate.

A traveling exhibit of photographs called "Pioneer Women Physicians of New Jersey" may be borrowed by New Jersey hospitals and hospital libraries from

UMDNJ-University Libraries. The exhibit features 20 pioneer women physicians—from 1830 to 1988—whose achievements have made history in New Jersey. The traveling exhibit is the photographic portion of an exhibition that opened last year at the UMDNJ-Smith Library in Newark. To schedule to exhibit, or for further information, call Barbara Irwin, UMDNJ-Smith Library, Newark, 201-456-6293. □ Stanley S. Bergen, J.D., MD, President

AMNJ REPORT

The Academy's Education Committee will hold a retreat on Wednesday, October 25, 1989, at the Manor in West Orange. The event will be cochaired by Dr. Richard Dixon and Dr. Stephen Wang. In addition to the Committee, members of the Board of Trustees and Section Officers will be invited to attend. Included in the program will be a presentation by Richard N. Pierson, Jr., M.D., professor of clinical medicine at Columbia University on "Remedial/Focused/Prescribed CME" and Jeffrey K. Stross, M.D., professor and associate chairman of the Department of Internal Medicine at the University of Michigan Medical School on "Mandatory CME."

The Academy of Medicine's Annual Awards Dinner will be held on Wednesday, May 23, 1990, at the Chanticleer in Short Hills. Please reserve the date now and note the nominations for the Edward J. and Citizen's Awards presently are being accepted.

The Academy of Medicine pleased to announce that we are the recipients of a grant from the

Medical Inter-Insurance Exchange of New Jersey to provide speakers in a variety of professional liability topics. The programs presently are being offered to hospitals, county medical societies, and specialty societies. There will be no fee for these events and they will be presented by experienced professionals associated with MIENJ.

Dr. Robert Eisinger again will chair this year's Internal Medicine Review Course, scheduled to begin on Wednesday, January 17, 1990, and run for 19 successive Wednesdays from 4:00-7:00 P.M. The course will be held at the Robert Wood Johnson University Hospital, New Brunswick, and will end on May 23, 1990. The course, co-sponsored by UMDNJ-Robert Wood Johnson Medical School and Robert Wood Johnson University Hospital, is designed to provide a comprehensive review of contemporary concepts in internal medicine. It is for practicing internists and family practitioners. The review also will be useful for residents in preparation for the ABIM exam. Syllabus material will be distributed during the course that, when compiled, will provide an extremely useful reference for all participants.

The Academy of Medicine of New Jersey and the Medical Society of New Jersey will cosponsor a course on "Techniques for Measuring the Value of a Medical Practice" on Sunday, October 15, 1989, from 2:00-5:00 P.M. at the Executive Offices in Lawrenceville. The course will be presented by David J. Shuffler, vice-president of Medical Banking, National Westminster Bank of New Jersey. More information can be obtained by contacting the Academy's Executive Offices.

The Fourteenth Annual New Jersey Orthopaedic Symposium, cosponsored by the Academy of Medicine of New Jersey and the New Jersey Orthopaedic Society, will be held on Friday and Saturday, October 27 and 28, 1989, at

the Somerset Marriott Hotel. Dr. Steven Berkowitz, program chairman, and Dr. Frederick Buechel, program secretary, have arranged for an outstanding program. The Complications/Resident's Thesis Conference will be held on Friday from 3:00 to 5:45 P.M. and members are encouraged to bring cases and complications for presentation. A cocktail party and dinner will follow at 6:00 P.M. Our special after-dinner speaker will be Robert E. Grady, associate director, Natural Resources, Energy and Science, Executive Offices of the President, Office of Management and Budget, Washington, D.C. Mr. Grady will address "What's Happening at the White House."

The all-day program on Saturday will feature the following guest speakers: Dr. John Connolly from the University of Nebraska College of Medicine; Dr. Adrian Flatt from Baylor University Medical Center; Dr. James Rand from the Mayo Medical School; Dr. John Sensakovic from Saint Michael's Medical Center; and Dr. Robert Zickel from St. Luke's-Roosevelt Hospital Center. Dr. William Robb, Chairman, Board of Councilors, American Academy of Orthopaedic Surgery will provide an update on AAOS activities.

The symposium is designed to provide an opportunity for orthopaedists in the tri-state area to hear timely topics of current interest presented by national leaders in various fields. □ Frederick B. Cohen, MD, President

■ PLACEMENT FILE ■

The following physicians have

written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY

Hak Joo Cha, MD, 22 Hamilton Ct., Lawrenceville, NJ 08648. Catholic Medical College 1972. Board eligible. Solo, partnership, group, fee-for-service. Available.

Ricky Zegelstein, MD, 4600 Ninth Ave., Brooklyn, NY 11220. Sackler 1984. Board eligible. Group or partnership. Available.

FAMILY PRACTICE

Leonid Belopolsky, MD, 955 Chanticleer Dr., Cherry Hill, NJ 08003. Moscow 1961. Board certified (ANES). Also, internal medicine. Available.

INTERNAL MEDICINE

Michael G. Donnelly, MD, 10 Overlook Rd., Apt. 4H, Summit, NJ 07901. Medical College of Pennsylvania 1987. Board eligible. Group or partnership. Available.

Leonid Belopolsky, MD, 955 Chanticleer Dr., Cherry Hill, NJ 08003. Moscow 1961. Board certified (ANES). Also, family medicine. Available.

ORTHOPEDICS

D.C. Brown, MD, 2319 Sayre Dr., Princeton, NJ 08540. Available.

Carl Paul Kessler, MD, 5517 Ramillete Rd., Las Vegas, NV 89120. Jefferson 1961. Board eligible. Group, partnership, multispecialty, industrial, state.

OTOLARYNGOLOGY

Samuel H. Selesnick, MD, 450 East 63rd St., #8F, New York, NY 10021. Board eligible. Available July 1990.

1990 MSNJ ANNUAL MEETING

The Medical Society of New Jersey will hold its Annual Meeting on Sunday, May 6, 1990, through Wednesday, May 9, 1990, at the Sands Casino and Country Club, in Atlantic City.

INTERNATIONAL CONFERENCES™

1990 CME CRUISE/CONFERENCES ON MEDICOLEGAL ISSUES AND SELECTED MEDICAL TOPICS— Caribbean, Bermuda, Alaska/Canada, New England, Scandinavia, W. Mediterranean, Europe, Asia, Trans Panama Canal. Approved for 20-28 CME Category 1 Credits (AMA/PRA) and AAFP prescribed credits. Distinguished lecturers. Excellent group fares on finest ships. Pre-scheduled in compliance with IRS requirements. **Information: International Conferences, 1290 Weston Road, Suite 316, Ft. Lauderdale, FL 33326. (800) 521-0076 or (305) 384-6656.**

Acupuncture & Electro-Therapeutics in Clinical Practice

New York State Boards of Medicine & Dentistry 25-hour accredited seminar & workshop on latest theories and techniques of manual & electro-acupuncture, TENS & simple non-invasive diagnostic methods (including cardio-vascular, neuromuscular, central nervous systems & "Bi-Digital O-Ring Test"), applicable towards 300-hour requirement for certification to practice acupuncture, will be given periodically for licensed clinicians (with or without prior training) on 3-day weekends (Fri-Sun) of Dec. 8-10, 1989 & Jan. 26-28, 1990, both at Milford Plaza Hotel, 45th St. & 8th Ave., New York City.

The 5th Annual International Symposium on Acupuncture & Electro-Therapeutics will be held at Columbia University, School of International Affairs, 420 W. 118th St., N.Y. City, during October 19-22, 1989.

These meetings are co-sponsored by the International College of Acupuncture & Electro-Therapeutics & its official journal, *Acupuncture & Electro-Therapeutics Research*. The *International Journal* (published by Pergamon Press & indexed in 15 major indexing periodicals, including Index Medicus), Heart Disease Res. Foundn, N Y Pain Center of Long Island College Hospital (a teaching hospital of SUNY-Health Science Center at Brooklyn); Electrical Engineering Dept., Manhattan College; Nordic Medical Acupuncture Society (Scandinavia); Schmerz Therapeutische Kolloquium (West Germany); Japan Bi-Digital O-Ring Test Assn; etc. The meetings are also eligible for AMA CME Cat. I credit (about 40 credit-hours for the Symposium).

For information on meetings or submission of papers, contact Symposium Chairman Y. Omura, M.D., Sc.D., 800 Riverside Drive (8-I) New York, NY 10032 Tel: (212) 781-6262 (10am to 10pm 7 days a week) or (212) 928-0658, Dr. Shinnick (212) 727-9674, or Bro. Michael Losco (212) 920-0162.

Are you spending more than
\$200/year

on Medical Waste Removal?

If you are a small generator

CALL

1-800-447-0026

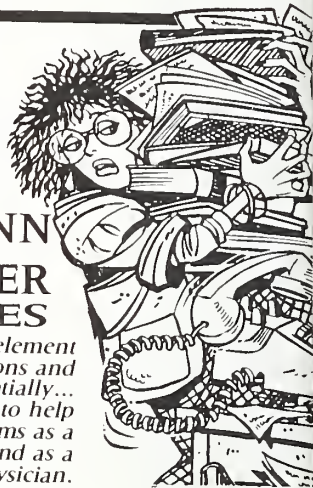
Doctors Disposal Service Inc.

*Licensed by the State of NJ,
is accepting new accounts*

*Your medical practice
is a business, and if
that business does not
run efficiently, it will
affect your patient and
public relations.*

MARY ANN HAMBURGER ASSOCIATES

*would evaluate each element
of your office operations and
work with you...confidentially...
on an individual basis, to help
you achieve your aims as a
businessperson and as a
practicing physician.*



Mary Ann can help by evaluating your:

- APPOINTMENT and/or SURGERY SCHEDULING • BILLING
- BOOKKEEPING • COLLECTIONS • CPT CODES and MACC
- PROFILES— ICD CODES • EQUIPMENT and SUPPLIES • FEE
- SCHEDULES • FILING SYSTEM • HIRING and TRAINING OF
- NEW and PRESENT PERSONNEL • INSURANCE (THIRD PARTY
- BILLING) • OFFICE LAYOUT and LOCATION • PATIENT FLOW
- RECALL SYSTEM • RECRUITMENT FOR HOSPITALS
- PURCHASING and SELLING of MEDICAL PRACTICES
- TELEPHONE MANAGEMENT

**Mary Ann can recommend specialists
for your business practice in these vital areas:**

- ACCOUNTING • FINANCE • INSURANCE • LAW

**Mary Ann Hamburger offers you many services
ranging from a one-time survey to a continuing service
in which she will make regular visits to your office
to help with any pending problems.**

74 HUDSON AVENUE
MAPLEWOOD, NEW JERSEY 07040 **763-7394**

CONTINUING EDUCATION

ALLERGY November In-Vitro Allergy Seminar Update Marriott's Hilton Head Resort, Hilton Head Island, South Carolina <i>(Holy Name Hospital)</i>	8 10:30-11:30 A.M.—Christ 15 Hospital, Jersey City 22 <i>(Christ Hospital)</i> 29 2 Arthritis 11 A.M.-12 Noon—St. Joseph's Hospital and Medical Center, Paterson <i>(AMNJ)</i>	New Brunswick <i>(Rutgers Community Health Plan)</i> 8 Postgraduate Medical 15 Education Series 22 8:30-9:30 A.M.—Alexian Brothers 29 Hospital, Newark <i>(Alexian Brothers Hospital)</i>
ANESTHESIOLOGY November Meeting 6-9 P.M.—Ramada Inn, Clark <i>(NJ Society of Anesthesiologists)</i>	2 Scientific Meeting All day <i>(New Jersey Society of Gastrointestinal Endoscopy)</i> 3 Continuing Medical Education Program 12 Noon-1 P.M.—United Hospitals Medical Center, Newark <i>(United Hospitals Medical Center)</i>	9 Emergency Medicine Annual Meeting 8 A.M.-5 P.M.—The Hyatt, Cherry Hill <i>(NJ Society of Critical Care Medicine)</i> 12 Organ Procurement 7-8 P.M.—Wallkill Valley General Hospital, Sussex <i>(AMNJ)</i>
CARDIOLOGY November Advanced Cardiac Life Support All day—Freehold Area Hospital, Freehold <i>(Freehold Area Hospital)</i>	3 Continuing Medical Education Program 10 12 Noon-1 P.M.—South Jersey 17 Hospital System, Bridgeton <i>(South Jersey Hospital System)</i>	13 Trauma Care in New Jersey 7-8 P.M.—Wallkill Valley General Hospital, Sussex <i>(AMNJ)</i> 13 Dually Diagnosed 1-2 P.M.—New Lisbon Developmental Center, New Lisbon <i>(AMNJ)</i>
December Saving Lives Post-MI 8:30 A.M.—United Hospitals Medical Center, Newark <i>(United Hospitals Medical Center)</i>	4 Recognition and Prevention and Treatment of Diabetic Complications 8:30 A.M.-4:30 P.M.—East Orange V.A. Medical Center, East Orange <i>(East Orange V.A. Medical Center)</i>	14 Renal Biopsy Conferences 12:30-2 P.M.—Barnert Memorial Hospital Center, Paterson <i>(Barnert Memorial Hospital Center)</i>
DERMATOLOGY November Robert Wood Johnson Medical School Dermatological Conferences 6-9 P.M.—Rutgers Community Health Plan, US #1, New Brunswick <i>(UMDNJ)</i>	7 Idiopathic Thrombocytopenia Purpura 11 A.M.-12 Noon—West Hudson Hospital, Kearny <i>(West Hudson Hospital)</i> 8 Refresher Course 8 A.M.-4:30 P.M.—Sheraton Hotel, New Brunswick <i>(NJ Academy of Family Physicians)</i>	14 Nephrotoxicity of Common Drugs 11 A.M.-12 Noon—Hunterdon Developmental Center, Clinton <i>(AMNJ)</i> 15 New Concepts in the Prevention of Nonsteroidal Anti-Inflammatory Drug-Induced Ulcers 11 A.M.-12 Noon—West Hudson Hospital, Kearny <i>(West Hudson Hospital)</i>
EDICINE November Retinopathy 2-3 P.M.—Hunterdon Developmental Center, Flemington <i>(AMNJ)</i> Intensive Review of Internal Medicine 11 A.M.-1 P.M.—Bayonne Hospital, Bayonne <i>(Bayonne Hospital)</i> Medical Lecture Series	8 Arthritis 10:30-11:30 A.M.—St. Mary's Hospital, Passaic <i>(AMNJ)</i> 8 Diabetes-Related Kidney Disease 12 Noon-1 P.M.—St. James Hospital, Newark <i>(AMNJ)</i> 8 Fall Continuing Medical Education Series 15 1:30-2:30 P.M.—Rutgers 22 Community Health Plan, 29	16 Continuing Medical Education

OFFICE COMPUTER SYMPOSIUM FOR PHYSICIANS AND THEIR STAFF NEW AND EXPERIENCED USERS

SATURDAY, NOVEMBER 4, 1989—8:30 A.M.-4:00 P.M.
MSNJ Executive Offices—Lawrenceville, New Jersey

Sponsored By

MEDICAL SOCIETY OF NEW JERSEY'S COMMITTEE OF YOUNG PHYSICIANS

Donald Cinotti, M.D.—Committee Chairman

Joseph Calderone, M.D.—Symposium Chairman

William Constad, M.D.—Symposium Co-Chairman

PARTICIPANTS

Thomas W. Reinke and William C. Garrow of Shotz, Miller and Glusman, Philadelphia, Pennsylvania

Diane Spencer of Amper, Politziner and Mattia, Edison, New Jersey

Both of these firms are experienced medical practice computer consultants.

Gail Rounds from Pennsylvania Blue Shield

Software/Hardware Exhibitors that do business in New Jersey, each with working systems on display

REGISTRATION FEE (Includes Lunch)

\$30 per person—MSNJ Member

\$60 per person—Non-Member

DEADLINE for Registration:

October 25, 1989

SCHEDULE

8:30- 9:30 a.m. Registration and Coffee

9:00-10:30 a.m. SESSION I

- Medical Office Computers—The State of the Art
- Selecting a Computer System—First Time or Replacement

10:30-11:00 a.m. Coffee Break

Meet the Exhibitors

11:00 a.m.-

12:30 p.m. SESSION II

- Installing the Computer System
- Organizing the Billing Department
- Current Trends in Billing Regulations

12:30-1:30 p.m. Lunch

Panel Discussion with Exhibitors

1:30-4:00 p.m. Exhibitors

Hands-on Comparisons

For Additional Information:

Call Ronald Rouse at (609) 896-1766

REGISTRATION FORM

(Make check payable to Medical Society of New Jersey)

NAME (Please Print): _____

ADDRESS: _____

TELEPHONE: (_____) _____ **MEDICAL SPECIALTY:** _____

NAME(S) OF ADDITIONAL PARTICIPANT(S): _____

DO YOU CURRENTLY HAVE AN OFFICE COMPUTER? YES _____ NO _____

Travel directions will be sent with confirmation.

- Series**
12 Noon—Somerset Medical Center, Somerville
(*Somerset Medical Center*)
- 8 **Challenging Problems in Neuropathology: 39th Annual Fall Slide Seminar**
9 A.M.-12 Noon—Robert Wood Johnson Medical School, Piscataway
(*New Jersey Society of Pathologists*)
- 21 **Diabetes in Pregnancy**
8-9 P.M.—Barnert Memorial Hospital Center, Paterson
(*AMNJ*)
- 22 **Dilemmas of Dying**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*AMNJ*)
- December**
- 1 **Lecture Series**
8 8:30-10 A.M.—United Hospitals
15 Medical Center, Newark
(*United Hospitals Medical Center*)
- 1 **Continuing Medical Education**
8 12 Noon-1 P.M.—South Jersey
15 Hospital System, Bridgeton
- 22 (*South Jersey Hospital System*)
- 29
- 1 **Treatment of Inflammatory Bowel Disease**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(*South Jersey Hospital System*)
- 1 **Diabetes in Pregnancy**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(*AMNJ*)
- 5 **Strokes**
10-11 A.M.—Green Brook Regional Center, Green Brook
(*AMNJ*)
- 5 **Electrolyte Imbalance and Management**
11 A.M.-12 Noon—West Hudson Hospital, Kearny
(*West Hudson Hospital*)
- 6 **Continuing Medical Education Series**
1:30-2:30 P.M.—Rutgers Community Health Plan, New Brunswick
(*Rutgers Community Health Plan*)
- 6 **Autologous Blood Transfusion**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
- (*AMNJ*)
- 6 **Medical Lecture Series**
13 10:30-11:30 A.M.—Christ
20 Hospital, Jersey City
27 (*Christ Hospital*)
- 7 **GI Advances in Peptic Ulcer Disease**
11 A.M.-12 Noon—St. Joseph's Hospital and Medical Center, Paterson
(*AMNJ*)
- 7 **Continuing Medical Education Series**
12 Noon—Somerset Medical Center, Somerville
(*Somerset Medical Center*)
- 12 **Renal Biopsy Conference**
12:30-2 P.M.—Barnert Memorial Hospital Center, Paterson
(*Barnert Memorial Hospital Center*)
- 13 **Orthotics and Prosthetics in the 1990s**
12 Noon-1 P.M.—St. Lawrence Rehabilitation Center, Lawrenceville
(*St. Lawrence Rehabilitation Center*)
- 15 **Viruses and Hematopoiesis**
8:30-10 A.M.—United Hospitals Medical Center, Newark
(*United Hospitals Medical Center*)
- 18 **Seizures**
1:30-3 P.M.—Marlboro Psychiatric Hospital, Marlboro
(*AMNJ*)
- 19 **Medical Grand Rounds**
9-10 A.M.—Holy Name Hospital, Teaneck
(*Holy Name Hospital*)
- 23 **Morbidity and Mortality**
30 **Conference**
8:30-10 A.M.—UMDNJ, Newark
(*UMDNJ*)
- 20 **Nephrotoxicity of Common Drugs**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 20 **Prevention of Lower Extremity Amputations**
12 Noon-1 P.M.—St. James Hospital, Newark
(*AMNJ*)
- 21 **Diabetes in Pregnancy**
8:30-9:30 A.M.—Dover General Hospital, Dover
(*AMNJ*)

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Category: (Please check one)

☐ Member, MSNJ ☐ Subscriber, NJ Medicine

☐ Other _____

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____

OBSTETRICS AND GYNECOLOGY

November

- 1 **Adolescent Menstrual Disorders**
10:30-11:30 A.M.—St. Mary's

PHILADELPHIA HEART INSTITUTE
of Presbyterian Medical Center

Cardiology Update

*designed for the physician and provides an intensive
survey of the current status of clinical cardiology. . .*

Wednesday, November 1, 1989 3:00-5:00 PM

Cardiac Imaging: For Whom & Why – Current Advances

Moderator

Ami E. Iskandrian, M.D.

3:00-3:30	Diagnostic techniques in patients with chronic coronary heart disease	Ami E. Iskandrian, M.D.
3:30-4:00	Cardiac Ultrasound: conventional and newer techniques	Jan R. Weber, M.D.
4:00-5:00	Case Presentations – Stable and unstable angina pectoris	Phillip Koren, M.D.
	Panel Discussion	
	Terry Langer, M.D.	Charles Gottlieb, M.D.
	Gary J. Vigilante, M.D.	J. David Ogilby, M.D.

- Case Presentations and Panel Discussions
- CME Credits*
- No Registration Fee
- Call for Reservation 662-8627

Scheie Auditorium
Presbyterian Medical Center
39th & Market Streets
Philadelphia, Pennsylvania 19104

*The Philadelphia Heart Institute at Presbyterian Medical Center is an affiliate of the University of Pennsylvania. "The University of Pennsylvania School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The University of Pennsylvania School of Medicine designates this Continuing Medical Education activity for 2 credit hours per session in Category 1 of the Physician's Recognition Award of the American Medical Association."

Hospital, Passaic
(AMNJ)

**Long-Term Consequences of
Estrogen Deprivation**

8:30-10 A.M.—United Hospitals
Medical Center, Newark
(United Hospitals Medical
Center)

Diabetes in Pregnancy

8-9 A.M.—Barnert Memorial
Hospital Center, Paterson
(AMNJ)

December

**Menopause and Estrogen
Replacement Therapy**

12 Noon-1 P.M.—South Jersey
Hospital System, Bridgeton
(South Jersey Hospital System)

ONCOLOGY

November

**Aspects of Cancer Screening for
the Health Care Professional**

8:30 A.M.-12 Noon—American
Cancer Society, Camden
(American Cancer Society and
Camden and Gloucester County
Societies)

Tumor Board Conference

12 Noon-1 P.M.—Wallkill Valley
Hospital Center, Sussex
(Wallkill Valley Hospital Center)

December

Annual Clinical Abstract

Meeting

1:30-5 P.M.—The Manor,
West Orange
(Oncology Society of New Jersey)

8 Tumor Board Meeting

11 A.M.-12 Noon—Wallkill Valley
Hospital Center, Sussex
(Wallkill Valley Hospital Center)

14 Dinner Meeting

6:30-9:30 P.M.—The Hyatt,
New Brunswick
(AMNJ—Head and Neck
Oncology Section)

28 Tumor Board Conference

12 Noon-1 P.M.—Newcomb
Medical Center, Vineland
(Newcomb Medical Center)

OPHTHALMOLOGY

November

15 Annual Scientific Meeting:

Modern Day Cataract Surgery
All day—Aspen Hotel, Parsippany
(NJ Academy of Ophthalmology
and Otolaryngology)

PEDIATRICS

November

1 Adolescent Menstrual Disorders

10:30-11:30 A.M.—St. Mary's
Hospital, Passaic
(AMNJ)

2 Pediatric Grand Rounds

9 8:30-9:30 A.M.—Robert Wood

16 Johnson Medical School, MEB,
30 102, New Brunswick

(UMDNJ)

30 Update in Aspects of Pediatrics

Marriott Hotel, Saddle Brook
(Northern NJ Pediatric Society)

December

7 Pediatric Grand Rounds

14 8:30-9:30 A.M.—Robert Wood
21 Johnson Medical School, MEB,
28 102, New Brunswick
(UMDNJ)

13 Update in Aspects of Pediatrics

Marriott Hotel, Saddle Brook
(Northern NJ Pediatric Society)

PSYCHIATRY

November

2 Electroconvulsive Therapy

12 Noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)

2 Psychiatric Aspects of AIDS

1:30-2:30 P.M.—Essex County
Hospital Center, Cedar Grove
(AMNJ)

2 Case Seminars To Improve

16 Psychotherapeutic Technique

8-10 P.M.—2 West Northfield
Road, Livingston
(Advanced Psychiatric Study
Group)

**8 18th Annual Lewis H. Loeser
Memorial Lecture**

8-10 P.M.—South Orange Middle
School, South Orange
(The Mental Health Association
of Essex County)

**9 Psychotherapy with Medically
Ill Patients**

12 Noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)

**15 The Many Faces of Depression
and Anxiety**

All day—Carrier Foundation,
Belle Mead
(Carrier Foundation)

**16 Horticultural Therapy: A Rose
Among Treatments**

12 Noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)

**30 Transference and
Countertransference Reactions
in the Management of
Ambulatory Schizophrenia**

12 Noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)

December

**7 Psychotherapy with Children
and Adolescents**

12 Noon-1 P.M.—Carrier

NEW JERSEY MEDICINE

presents

**Continuing
Medical Education
in New Jersey**

\$5.00

September 1989

Send check to: NEW JERSEY MEDICINE
Two Princess Road
Lawrenceville, NJ 08648
609/896-1766



CLINICAL UPDATE PULMONARY MEDICINE

November 29, 1989

COURSE DESCRIPTION:

The 6th Annual Clinical Update is designed to provide family practitioners, general intern pulmonologists, and other interested physicians with an updated review of pulmonary disorders which commonly encountered in clinical practice as well as certain disorders which are of current topical interest. The program has been carefully selected to ensure a good blend of established and new methods and approaches to pulmonary diseases.

The morning session will provide participants with systematic approaches to chest x-ray interpretation, asthma, tuberculosis and chronic obstructive pulmonary disease.

The afternoon session will present current concepts in the diagnosis and management of asbestosis, pulmonary thromboembolism, and drug-induced lung disease. A special lecture will focus on the current status of alpha₁-antitrypsin replacement therapy in hereditary emphysema.

Throughout the day, emphasis will be placed on risk factors, natural history, early detection, prognostic factors, newer diagnostic techniques and new methods of therapy.

A.M.

MORNING SESSION

- 8:00 Registration
- 8:50 Welcome—*Vladir Maranhao, M.D.*
- 9:00 A Practical Guide to Chest X-Ray Interpretation
Wallace T. Miller, M.D.
- 9:50 "Asthma: Current Concepts in Pathophysiology and Therapy"
James E. Fish, M.D.
- 10:40 Coffee Break
- 10:55 "Evaluation and Management of COPD in 1989"
David M.F. Murphy, M.D.
- 11:45 "Current Approach to Tuberculosis in the Era of HIV Infection"
Elias Abrutyn, M.D.

P.M.

AFTERNOON SESSION

- 12:30 Luncheon
- 1:30 Clara Falk Franks Lecture—"Alpha₁-Antitrypsin Deficiency: A Treatable Hereditary Disorder"
Ronald G. Crystal, M.D.
- 2:20 "Deep Vein Thrombosis and Pulmonary Embolism: Diagnosis and Pathophysiology"
Mark A. Kelley, M.D.
- 3:10 Coffee Break
- 3:25 "Asbestosis: Clinical Disorders Associated with an Inorganic Material"
Ronald G. Crystal, M.D.
- 4:15 "Drug-Induced Lung Disease"
Mervyn Feierstein, M.D.

GUEST FACULTY

ELIAS ABRUTYN, M.D., Professor and Assistant Chairman, Department of Medicine, Medical College of Pennsylvania, Chief, Infectious Diseases, Veterans Administration Medical Center, Philadelphia, Pennsylvania

RONALD G. CRYSTAL, M.D., Chief, Pulmonary Branch, Division of Pulmonary Medicine and Critical Care, Jefferson Medical College, Philadelphia, Pennsylvania

MARK A. KELLEY, M.D., Associate Professor and Vice Chairman, Department of Medicine, Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania

WALLACE T. MILLER, M.D., Professor and Vice Chairman, Department of Radiology, Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania

LOCAL FACULTY

MERVYN FEIERSTEIN, M.D., Program Director, Attending Pulmonologist, Department of Pulmonary Medicine, Deborah Heart and Lung Center, Browns Mills, New Jersey

DAVID M.F. MURPHY, M.D., Program Chairman, Chairman, Department of Pulmonary Medicine, Deborah Heart and Lung Center, Browns Mills, New Jersey

SIXTH ANNUAL CLINICAL UPDATE IN PULMONARY MEDICINE

Sponsored by:

Deborah Heart and Lung Center
Browns Mills, New Jersey
(609) 893-6611

Wednesday, November 29, 1989

NAME _____

ADDRESS _____

CITY/STATE _____

ZIP _____

SPECIALTY _____

PHONE (_____) _____

Tuition: All participants, fee includes luncheon and refreshments—\$90.00.

A check in the amount of \$90.00 payable to Deborah Heart and Lung Center should accompany this application. Mail to Pulmonary Department, Deborah Heart and Lung Center, Browns Mills, N.J. 08015.

Due to limited seating capacity, early registration is strongly advised. Registration deadline—Wednesday, November 15, 1989.

Accreditation: Deborah Heart and Lung Center designates that this continuing medical education offering meets criteria for 6.5 credit hours in category 1 of the Physician Recognition Award of the American Medical Association. This program has been reviewed and is acceptable for prescribed hours by the American Academy of Family Physicians.

For Program Information please call: Mrs. Diane Colby (609) 893-6611.

Foundation, Belle Mead
(*Carrier Foundation*)

Psychiatry and the Law
1:30-2:30 P.M.—Essex County
Hospital Center, Cedar Grove
(*AMNJ*)

**Case Seminars To Improve
Psychotherapeutic Technique**
8-10 P.M.—2 West Northfield
Road, Livingston
(*Advanced Psychiatric Study
Group*)

Anxiety Disorders
11 A.M.-12 Noon—Woodbridge
Developmental Center,
Woodbridge
(*AMNJ*)

Voluntary Self-Help Groups
12 Noon-1 P.M.—Carrier
Foundation, Belle Mead
(*Carrier Foundation*)

**Psychopathology in Dually
Diagnosed Adolescents**
12 Noon-1 P.M.—Carrier
Foundation, Belle Mead
(*Carrier Foundation*)

MONOLOGY

November

Update in Pulmonology
12 Noon-1 P.M.—South Jersey
Hospital System, Bridgeton
(*South Jersey Hospital System*)

**Screening and Treatment of
Tuberculosis**
2:30-3:30 P.M.—Ancora
Psychiatric Hospital,
Hammonton
(*AMNJ*)

**Sixth Annual Clinical Update in
Pulmonary Medicine**
8 A.M.-5 P.M.—Deborah Heart
and Lung Center, Browns Mills
(*Deborah Heart and Lung Center*)

December

Occupational Lung Disorders
12 Noon-1 P.M.—South Jersey
Hospital System, Bridgeton
(*South Jersey Hospital System*)

DIOLOGY

November

Meeting
7:30-9:30 P.M.—The Manor,
West Orange
(*New Jersey Institute of
Ultrasound in
Medicine/Radiological Society of
New Jersey/AMNJ*)

1989 Scientific Meeting
7:30-9:30 P.M.—Saint Barnabas
Medical Center, Livingston
(*Radiological Society of
New Jersey-Diagnostic Section,*

AMNJ)

23 Visiting Professor Program
1:30-5 P.M.—Saint Barnabas
Medical Center, Livingston
(*Saint Barnabas Medical Center*)

29 Dinner Meeting
6 P.M.—The Hyatt,
New Brunswick
(*Radiation Oncology
Section—AMNJ*)

December

21 1989 Scientific Meeting
7:30-9:30 P.M.—Saint Barnabas
Medical Center, Livingston
(*Radiological Society of
New Jersey-Diagnostic Section,
AMNJ*)

28 Visiting Professor Program
1:30-5 P.M.—Saint Barnabas
Medical Center, Livingston
(*Saint Barnabas Medical Center*)

SURGERY AND ITS SPECIALTIES

November

3 Peripheral Vascular Disease
12 Noon-1 P.M.—South Jersey
Hospital System, Bridgeton
(*South Jersey Hospital System*)

**4 Surgical Treatment of
Cardiothoracic Disease**
11 10-11:30 A.M.—New Jersey
Medical School, MSB, 506B,
Newark
(*UMDNJ*)

**5 Surgical Treatment of
Cardiothoracic Disease**
10-11:30 A.M.—New Jersey
Medical School, MSB, 506B,
Newark
(*AMNJ*)

**7 Weekly Vascular Case
Conference**
21 7:30-8:30 A.M.—Robert Wood
Johnson Medical School, MEB,
108B, New Brunswick
(*UMDNJ*)

9 Reconstructive Microsurgery
11 A.M.—St. Joseph's Hospital
and Medical Center, Paterson
(*St. Joseph's Hospital and
Medical Center*)

**18 Morbidity and Mortality
Conference**
25 8:30-10 A.M.—New Jersey
Medical School, MSB, 506B,
Newark
(*UMDNJ*)

**28 Englewood Surgical Society
Lecture Series**
8-10 P.M.—The Englewood Club,
Englewood
(*Englewood Surgical Society*)

**29 Journal Club, Section of
Cardiothoracic Surgery**
6:30-9:30 P.M.—2 Mountain Ridge

Drive, Livingston
(*UMDNJ*)

December

2 38th Annual Meeting
8:30 A.M.-4:30 P.M.—Sheraton
Tara, Parsippany
(*New Jersey Chapter, American
College of Surgeons*)

2 Surgery of the Great Vessels
9-10:30 A.M.—St. Joseph's
Hospital and Medical Center
(*St. Joseph's Hospital and
Medical Center*)

**3 Surgical Treatment of
Cardiothoracic Disease**
6:30-9:30 P.M.—New Jersey
Medical School, MSB, 506B,
Newark
(*UMDNJ*)

**5 Weekly Vascular Case
Conference**

**12 7:30-8:30 A.M.—Robert Wood
Johnson Medical School, MEB,
108B, New Brunswick
(UMDNJ)**

**2 Surgical Treatment of
Cardiothoracic Disease**
9 10-11:30 A.M.—New Jersey
Medical School, MSB, 506B,
Newark
(*UMDNJ*)

**16 Morbidity and Mortality
Conference**
23 8:30-10 A.M.—New Jersey
Medical School, MSB, 506B,
Newark
(*UMDNJ*)

27 Journal Club
6:30-9:30 P.M.—2 Mountain Ridge
Drive, Livingston
(*UMDNJ*)

UROLOGY

November

3 Urology Grand Rounds
10 New Jersey Medical School,
17 MSB, C600, Newark
24 (*UMDNJ*)

8 Fall Meeting
9 A.M.-4 P.M.—MSNJ
Headquarters, Two Princess
Road, Lawrenceville
(*Urology Society of New Jersey*)

December

1 Urology Grand Rounds
8 New Jersey Medical School,
15 MSB, C600, Newark
22 (*UMDNJ*)

**29 Extracorporeal Shockwave
Lithotripsy**
10:30-11:30 A.M.—St. Mary's
Hospital, Passaic
(*AMNJ*)

Let's Work Together

The practice of medicine has gone through a period of unprecedented accomplishments since the 1940's. Life expectancy continues to lengthen and the quality of life continues to improve. There is more that remains to be done. We must all stand together — physicians and patients to find

solutions to the problems that remain. We must solve the problems of providing adequate physical and mental health services and long term out of the hospital care for our aging population. From early civilization, service to mankind has been the leading principle of medical practice.

Physicians devote considerable time and effort without seeking recognition or reward. Sixty-eight percent of primary care physicians voluntarily give time at free clinics, nursing homes and other social service health care facilities. One-third of the care given by emergency physicians is donated. Most New Jersey physicians are cooperating in the Voluntary Medicare Assignment Program. The Medical Society of New Jersey, with the cooperation of the county medical societies, is working in conjunction with the Office on Aging and the Senior Citizen Council to provide a Senior Medical Courtesy Program. Contact your county medical society for further information. Every day in the



USA, four million patients interact with physicians giving the medical profession an opportunity to demonstrate their competence, caring and devotion to each patient they serve.

Hopefully major issues such as Medicare, drug abuse, professional liability, AIDS, and the ration-

ing of health care will be addressed in the public forum. It is there that the public and the medical profession can meet in a non-adversarial role to plan the future of medical care that will confront the issues of today rather than confound them with non-productive political windstorms filled with empty promises. Bureaucratic fiat and controls will not insure quality care.

The American medical system is truly one of our country's greatest treasures. Beware of changes that make it difficult if not impossible to protect the quality of care patients deserve and expect.

The medical profession has been requesting Medicare reform and the public should also urge Congress to honestly address the need for Medicare reform.

Your County Medical Society and
**The Medical Society
of New Jersey**

2 PRINCESS RD., LAWRENCEVILLE, N.J. 08648

IN MEMORIAM

William R. Jacobs. A family practitioner, William Robert Jacobs, MD, died on June 16, 1989, at the age of 61. Born in 1928 in Phillipsburg, Dr. Jacobs earned his medical degree at Jefferson Medical College of Philadelphia in 1954 and was awarded his New Jersey license in 1955. During his career, Dr. Jacobs was affiliated with Warren Hospital, Phillipsburg; he was a member of our Warren County component and of the American Medical Association, and was a diplomate of the American Board of Family Practice.

Frederick R. Kanning. Former Allendale school physician, Frederick Richard Kanning, MD, died on May 31, 1989, at the age of 86. Born in 1902, Dr. Kanning was a 1931 medical graduate of the University of Minnesota. During his lengthy career as a family physician, Dr. Kanning was affiliated with The Valley Hospital, Ridgewood. Dr. Kanning was a member of our Bergen County component and of the American Medical Association.

Theodore Keith. Word has been received of the death of Theodore Keith, MD, on July 15, 1989. Born in 1908 in North Carolina, Dr. Keith earned his medical degree from Temple University School of Medicine, Philadelphia, Pennsylvania, in 1936. He served an internship at Passaic General Hospital in 1937, and was awarded his New Jersey license in the same year. Dr. Keith was a pioneer at Passaic General Hospital where he developed the cardiac unit. He was a member of our Passaic County

component and of the American Medical Association, a diplomate of the American Board of Internal Medicine, and a fellow of the American College of Cardiology.

Henry J. Konzelmann. A member of our Union County component and of the American Medical Association, Henry Joseph Konzelmann, MD, died on June 4, 1989. Dr. Konzelmann was a resident of Hillside for 38 years and of Sea Girt for 20 years. Born in 1904 in West Hoboken, Dr. Konzelmann was awarded a medical degree from Georgetown University School of Medicine in 1930. An internist, Dr. Konzelmann was affiliated with St. Elizabeth Hospital and Alexian Brothers Hospital, both in Elizabeth. He retired from active practice in 1969 and worked as a consultant for the state until he retired completely in 1985. Dr. Konzelmann served as president of the Union County Medical Society in 1961 and in the same year received the Doctor of the Year Award from the Union County Heart Association.

Joseph Levin. A retired member of our Essex County component, Joseph Levin, MD, died on May 23, 1989, at the age of 88. Born in 1901 in Russia, Dr. Levin earned his degree at the University of Maryland Medical School in 1926; he was licensed to practice medicine in New Jersey in 1928. An internist, Dr. Levin retired in 1972 after 44 years in medicine; during his career he was affiliated with Presbyterian Hospital and Newark City Hospital, both in Newark. He was a member of the

American Medical Association and a fellow of the American College of Cardiology.

Martin Lowenthal. At the age of 67, Martin Lowenthal, MD, died on March 16, 1989. Dr. Lowenthal was a member of our Essex County component and of the American Medical Association; he was a fellow of the American College of Chest Physicians and of the American College of Cardiology, and a diplomate of the American Board of Internal Medicine. A 1945 graduate of Cincinnati Medical School, Ohio, Dr. Lowenthal was an internist affiliated with The Mountainside Hospital and St. Vincent's Hospital, both in Montclair; Martland Hospital, Newark; and Flower and 5th Avenue Hospital and Metropolitan Hospital, both in New York.

Saverio A. Monaco. A Newark physician for 50 years, Saverio Anthony Monaco, MD, died on June 6, 1989. Born in 1910 in Newark, Dr. Monaco received his medical degree from Hahnemann Medical College, Pennsylvania, in 1936, and was awarded his New Jersey license in 1937. Dr. Monaco was a staff physician for the Newark Health Department until his retirement in 1987. A member of our Essex County component and of the American Medical Association, Dr. Monaco was affiliated with Clara Maass Medical Center, Belleville, and Columbus Hospital, Newark. He received MSNJ's Golden Merit Award in 1987. Dr. Monaco participated in the Normandy Invasion on D-Day and in the Battle of the Bulge.

EDITORIAL CRITERIA

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. All material published is copyrighted by the Medical Society of New Jersey.

Content. The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevant to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made to an audience in New Jersey.

Assignment of Copyright. In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statement accompany-

ing material offered to *NEW JERSEY MEDICINE* must contain the following language and must be signed by all authors.

"In consideration of *NEW JERSEY MEDICINE* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *NEW JERSEY MEDICINE*.

Specifications. Submit two manuscripts that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods should be identified.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests and correspondence should be sent.

The author should submit a 30-word abstract.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission must be submitted.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

References should not exceed citations except in review articles and should be cited consecutively by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in numerical order. The style of *NEW JERSEY MEDICINE* for references is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

Publication Policy. Receipt of each manuscript will be acknowledged; the paper will be referred to the Editorial Board. The final decision is reserved for the editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. Galley proofs will be submitted to the author for correction.

Reprint Orders. Reprints may be ordered after the author is notified that the article has been selected for a specific issue. A check for the cost of reprints must accompany that order.

Communications. All communications should be sent to the editor, *NEW JERSEY MEDICINE*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

NEW JERSEY MEDICINE

1990

Publisher: Medical Society of New Jersey
Advertising Office: 609-393-7196

Advertising Representative:
(pharmaceutical)

Advertising Representative: Cookson Media Services, Inc.
(non-pharmaceutical) 370 Morris Avenue
Trenton, NJ 08611
609-393-7196

United Media Associates
16 Bruce Park Avenue
Greenwich, CT 06830
203-661-9702

General Information

1. Issuance:

- a. Frequency: Monthly
- b. Issue date: 10th of month
- c. Mailing date: 10th of month

2. Established: 1904

3. Organization Affiliation:

Official publication of the
Medical Society of New Jersey

4. Circulation Data:

a. Controlled circulation to all members of the Medical Society of New Jersey. Member's subscription is included in Society dues. Rates for nonmembers \$35, outside USA add \$15 for postage. Single copies \$3 except special issues.

b. Annual percentage of subscription renewals: 100% of members.

c. Number of issues sent after subscription expiration: None.

5. Special Issue:

Index (December)

6. Editorial Content:

Membership Newsletter, Professional Liability Commentary, Editorials, Physician Legal Bulletin, Hospital Governing Boards, Scientific Articles, Special Articles, Case Reports, Commentary, Contemporary Clinical Nutrition, Impaired Physicians Program, Medical News and Meeting Notices; Trustees' Minutes, State Legislation, Annual Meeting, Medical Insurance, Continuing Medical Education, JEMPAC Reportorial, Review Articles, State-of-the-Art Articles, The Electrocardiogram, Non-Invasive Cardiology, Pediatric Briefs, Clinical Notes, Your Congressman Speaks, Doctors' Notebook, Letters to NEW JERSEY MEDICINE, Personal Items, Obituaries, Book Reviews, Medical Histories.

7. Requirement for Acceptance of New Professional Products for Advertising.

All advertising subject to Publication Committee approval.

8. Requirement for Advertising Clearance:

All advertising subject to Publication Committee approval.

9. Advertising Acceptance of Nonprofessional Products or Services:

All advertising subject to Publication Committee approval.

10. Policy on Placement of Advertising:

Advertising is interspersed throughout the publication. All R.O.B. ads are rotated each month. Advertising and editorial material is not placed on the same page.

11. Advertiser's Index:

None.

12. Services to Advertisers:

Availability of editorial reprints: Please direct such requests to the Executive Editor.

13. Staff:

Editor-In-Chief: Howard D. Slobodien, M.D.; Executive Editor: Geraldine R. Hutner; Executive Director: Vincent A. Maressa.

14. Circulation:

All members of the Medical Society of New Jersey.

15. Guaranteed Circulation:

All members of the Medical Society of New Jersey.

16. Circulation Verification:

Publisher's statement, postal receipt verification.

17. Rates Per Thousand:

Based on the 12-times rate of \$520.00 and circulation of 10,700: \$48.60.

NEW JERSEY MEDICINE

Rate Card effective January 1990

18. Coverage and Market

a. Coverage: All members of the Medical Society of New Jersey, plus trade circulation.

b. Physician Count:

Internal Medicine	1,995
Family Practice	1,352
Surgery	897
Obstetrics/Gynecology	690
Pediatrics	585
Orthopedics	514
Ophthalmology	371
Anesthesiology	363
Radiology	342
Psychiatry	334
Cardiology	260
Urology	228
Neurology	216
Dermatology	179
Otolaryngology	173
Pathology	169
Industry/Administration	166
Allergy	70
Oncology	64
Rehabilitative Medicine	65
Geriatrics	5
Faculty, Residents, Students & Misc.	532
Total	9,570

c. Trade Circulation:

Non-member physicians	
Medical libraries	
Medical schools	
Drug manufacturers	
Medical book publishers	
Medical abstract services	
Advertisers	
Advertising agencies	
Subscriptions	
Total approximately	1,150

d. Readership Survey: Readership surveys by Health Industries Research and FOCUS show that NEW JERSEY MEDICINE is extremely well read. Copies are available upon request.

19. MEMBERSHIP CIRCULATION BY COUNTIES OF STATE OF NEW JERSEY

Atlantic	38
Bergen	1,38
Burlington	24
Camden	20
Cape May	10
Cumberland	16
Essex	1,5
Gloucester	4
Hudson	5
Hunterdon	8
Mercer	4
Middlesex	13
Monmouth	6
Morris	8
Ocean	8
Passaic	6
Salem	21
Somerset	2
Sussex	9
Union	9
Warren	10
Total	9,5

Guaranteed Circulation: 10,700

NEW JERSEY MEDICINE

Rate Card effective January 1990

Rates

0. Issuance:

- a. Frequency: Monthly
- b. Issue Date: 10th of month
- c. Mailing Date: 10th of month

1. Closing Dates for Space:

- a. Reservations: 1st of month preceding month of issue
- b. Cancellations: 6th of month preceding month of issue

2. Agency Commission:

15%

3. Cash Discount:

2%, 10 days

4. Black and White Rates Per Insertion:

	1X	3X	6X	12X
One page	\$550	\$540	\$530	\$520
1/2 page	285	280	275	270
1/4 page	155	150	145	140
1/8 page	80	80	75	70

Classified: Available to member physicians only

5. Earned Rates:

Rates based on number of insertions used within one year, regardless of size. Space purchased by a parent company and subsidiaries is combined for accounting of earned rates.

26. Color Rates:

- a. Standard color \$250 plus earned black and white rate.
- b. List of standard colors: AAAA standard red, green, blue, yellow, orange.
- c. Matched Colors: \$300 plus earned black and white rate.
- d. 4-color rate: \$600 plus earned black and white rate.

27. Bleed

No bleed charge.

28. Inserts:

- 60 pound coated only.
- 2 page furnished inserts—2x b/w rate; 4 page furnished inserts—4x b/w rate.

29. Preferred Position Rates:

- a. Preferred position rates quoted on request and subject to availability.
- b. Should an advertiser insist on a specific position, production requirements may dictate premium rates.

30. Miscellaneous:

- a. Contract requirements: All contracts subject to publisher's approval.
- b. Statement of guarantee of uniform rates and discounts to all advertisers using same amount and kind of space: No exceptions to published rates.
- c. Concessions: None.
- d. Rates subject to change with 90 days notice. Contracts accepted with understanding that rates will be guaranteed for three months beyond last issue closed. In the event of rate increase, contracts may be terminated without penalty of short rate.

NEW JERSEY MEDICINE

Rate Card effective January 1990

Mechanical Requirements

New Jersey Medicine is printed by offset.
Trim size: 8 x 11

31. Plate Sizes:

Page Unit	Dimensions (width x depth)
1 full page	7 x 10
1/2 horizontal	7 x 4-7/8
1/2 vertical	3-3/8 x 10
1/4 vertical	3-3/8 x 4-7/8
1/8 vertical	3-3/8 x 2-3/8

32. Bleed Sizes:

Page Unit	Dimensions (width x depth)
1 full page	8-1/8 x 11-1/4
1/2 horizontal	8-1/8 x 5-5/8
1/2 vertical	4-1/16 x 11-1/4

33. Insert Requirements:

Untrimmed size—8-1/4 x 11-1/4
Quantity—12,000

34. Paper Stock:

Covers: 80-pound. Inside pages: 55, or 50 pound.

35. Type of Binding:

Perfect bound.

36. Halftone Screen:

Up to 133 screen.

37. Reproduction Requirements:

Black and white positives and 2-color advertisements: negatives, camera-ready mechanicals, and art work acceptable.

4-color: film negatives or positive separations and press proof.

Offset film negatives or positives on .002 or .004 stable base materials must have register marks, center marks and trim marks clearly indicated. Each negative must be marked for color and be right reading emulsion side down.

38. Closing Dates:

a. Negatives or positives, camera ready mechanicals, and art work: 10th of the month preceding month of issue.

b. Publication set copy: 5th of month preceding month of issue.

c. Contact advertising office (609-393-7196) if extensions necessary. All extensions subject to approval.

39. Disposition of Reproduction Material:

Material is held for one year and then destroyed.

40. "Dual Responsibility":

Billing directed to the advertising agency at the net rate is approved on condition that the advertiser will accept "dual responsibility" for payment if the agency does not remit within 90 days. Advertiser's accounts in arrears 60 days will be billed in duplicate to both the agency and the advertiser.

41. Addresses:

Non-Pharmaceutical Sales, general information:

Cookson Media Services, Inc.
370 Morris Avenue
Trenton, NJ 08611
609-393-7196

Pharmaceutical Sales:

United Media Associates, Inc.
16 Bruce Park Avenue
Greenwich, CT 06830
203-661-9702

Contracts and insertion orders:

Advertising Office
NEW JERSEY MEDICINE
370 Morris Avenue
Trenton, NJ 08611
609-393-7196

Reproduction material:

Advertising Office
NEW JERSEY MEDICINE
370 Morris Avenue
Trenton, NJ 08611
609-393-7196

Inserts: (12,000)

NEW JERSEY MEDICINE
c/o Hughes Printing Company
34 North Crystal
East Stroudsburg, PA 18301



PROFESSIONAL LIABILITY

FIGHTING RETROACTIVE JUA ASSESSMENTS

A group of Massachusetts physicians, calling themselves the "Liability Investigation Fund Effort," have sued the state, its insurance department, and the Medical Malpractice Joint Underwriting Association to prevent imposition of retroactive premium assessments. The group asserts that \$248 million in retroactive assessments which the JUA seeks to collect are illegal because they violate state and federal constitutional rights of due process and bar against retroactive assessments.

The JUA, the state's major provider of medical liability insurance, says the assessments are needed to maintain its financial stability. In March, the Alliance of American Insurers noted that the financial condition of the Massachusetts JUA was deteriorating rapidly. JUA says it told physicians that premiums paid for years 1983 to 1985 were provisional because it was appealing an insurance department ruling that kept rates from increasing to levels JUA actuaries deemed appropriate. Later, the state's high court approved additional increases and the JUA began trying to collect the differences in the premiums for those years. (*Medical Liability Monitor*, June 23, 1989)

HEDONIC DAMAGES AWARDED TO PATIENTS

New York's highest court has ruled that hedonic damages, or the loss of pleasure derived from the pursuits of life, should be considered by the jury as a component of pain and suffering as opposed to a distinct element of noneconomic damages. The court also ruled that, like other pain and suffering claims, a claim for loss of enjoyment of life requires a showing of some degree of cognitive awareness on the part of the injured patient. *McDougald versus Garber*, N.Y.S.2d (N.Y.Ct. of App., Feb. 21, 1989).

The patient was a 31-year-old woman who suffered severe brain damage and lapsed into a permanent coma after an anesthesia injury during a cesarean section. A New York trial court awarded the patient a total of \$9,650,102, including \$1 million for conscious pain and suffering and \$3.5 million for loss of the pleasures and pursuits of life, with the remainder awarded for lost earnings, future custodial care, and other economic damages. In addition, the patient's husband was awarded \$1.5 million on his claim for loss of consortium. In the course of post-trial motions, the trial judge reduced the separate awards for conscious pain and suffering and loss of the pleasures and pursuits of life to a single award of \$2 million, and the appellate court affirmed. *McDougald versus Garber*, 524 N.Y.S.2d 192 (N.Y.Sup.Ct., App.Div., Jan. 28, 1988).

In a further appeal to New York's highest court, the court of appeals, the physicians again challenged the \$2 million award for noneconomic damages, arguing that the patient's comatose state prevented her from experiencing either pain or the loss of enjoyment. The trial court had held that cognitive awareness was an integral component to a claim for pain and suffering, but that no such awareness was required to support a claim for loss of the enjoyment of life. The court of appeals rejected the latter argument, on the theory that damages for noneconomic injuries are intended primarily to provide a measure of solace for the

condition created. Conversely, when damages cease to serve these compensatory goals, they become punitive, which is not their intended purpose. From these premises, the court reasoned that the award of monetary damages to a person whose injuries preclude any awareness of the loss can provide no consolation or ease any burden resting on him, and therefore can serve no compensatory purpose. Hence, the court concluded that some degree of cognitive awareness must be present to recover for both pain and suffering and loss of enjoyment of life.

In reaching this conclusion, the court of appeals rejected the patient's argument that the magnitude of damages should in all cases reflect and therefore increase in accordance with the severity of the injury. The court held that such "retributive symmetry" was rooted in a desire to punish the defendant in proportion to the harm inflicted, but had nothing to do with meaningful compensation for the victim, which is the goal of the tort system.

The court of appeals also rejected the patient's argument that the loss of enjoyment of life and pain and suffering should be treated as distinct elements of damages. Noting that there is a split among the states on the decisions on this question, the New York court determined that a legitimate compensatory goal would be achieved in allowing the patient to argue that these noneconomic losses should be separately considered. Rather, the court feared that there in fact would be a duplication resulting from the jury's "murky process in translating pain and suffering in dollars and cents." Moreover, the court decided that the concept of suffering could easily encompass the frustration and anguish caused by the inability to participate in activities that once brought pleasure.

Therefore, the court ordered a new trial on the issue of damages for pain and suffering to be based on a jury's assessment as to whether the patient has "some level" of cognitive awareness. The jury is not required to sort out varying levels of awareness and "determine at what level a particular deprivation can be fully appreciated."

A dissenting opinion joined by two justices argued that while cognitive awareness is a legitimate prerequisite to pain and suffering, the tort system's compensation goals would be better served in dropping the requirement when considering loss of enjoyment of life. According to these justices, whether or not the monetary award has meaning or utility to a comatose patient, it is a substitute for something that, like a lost limb, has been wrongfully taken. While pain and suffering damages compensate the claimant for the actual physical and mental discomfort caused by the injury, the dissent argued that the purpose of awarding damages for loss of enjoyment of life is to compensate the victim for the limitations on life created by the injury. Hence, there is no overlap between pain and suffering and loss of enjoyment damages.

One interesting aspect of the court of appeals' decision in *McDougal* is that the majority clearly expresses its concern for limiting damages in medical malpractice cases. While acknowledging that there is, in fact, a theoretical distinction between conscious pain and suffering and loss of enjoyment of life, the court was persuaded by the fact that acknowledging this distinction with separate jury instruction would be used by the plaintiffs' bar to obtain higher jury verdicts. In the course of its discussion, the majority opinion cautions that fair compensation is not necessarily more compensation. The majority opinion also expresses serious concern about the objectivity of the jury's process for determining the cost of nonquantifiable damages.

In Illinois, a jury awarded hedonic damages of \$1.02 million, part of a \$2.3 million award for a patient in a medical malpractice lawsuit. In September 1986, the patient's gynecologist diagnosed cancer of the uterus based on the results of a Pap test. A second Pap test and two biopsies showed no cancer. Nevertheless, the gynecologist ordered a series of radiation treatments, which resulted in her bladder shrinking and a limited ability to bend. The patient sued both the gynecologist and the radiologist who administered the radiation treatments. The jury found that the treatments were needless and awarded her damages for her loss of the pleasures of life. For example, this patient, who was retired, enjoyed gardening and walking five miles a day, activities she no longer was able to perform.

The patient's attorney stated that usually damages in cases such as these are tied to the patient's lost future wages; however, this patient was retired. Therefore, the patient's attorney hired an economist who used a combination of government and academic data, psychological testing, and hypotheticals derived from economists' analyses of human behavior to determine a dollar value for damages. The jury awarded more than the economist recommended.

The attorneys for the two physicians have said they will appeal the verdict and the award. *Ferguson versus Mucci*, Dkt. No. 87027 (Circuit Court of Madison County, IL, March 15, 1989) (*Wall Street Journal*, March 23, 1989).

Unlike the patient in *McDougald*, the patient in Illinois is conscious and aware of those pleasures she can no longer enjoy. Nevertheless, one of the questions to be resolved on appeal in Illinois will be whether hedonic damages should be considered to be different and separate from damages for pain and suffering, or should the loss of the ability to enjoy life be considered one type of suffering to be included in an award for pain and suffering.

Both the New York case and the Illinois case involve medical malpractice, but the concept of hedonic damages could be applied to all types of personal injury and wrongful death claims. Appellate courts in California and Iowa have refused to accept hedonic damages as separate from pain and suffering, using reasoning similar to the New York court of appeals; but one federal appellate court and appellate courts in Wyoming and Pennsylvania have allowed separate awards on the grounds that two types of suffering are analytically distinguishable. A Nebraska appellate court and a federal appellate court questioned the propriety of separate awards but held that in these particular cases, separate awards did not constitute reversible error. If the concept of hedonic damages becomes widely accepted in the state courts, there could be an increase in damage awards and a subsequent increase in insurance premiums. (Martin J. Hatlie, JD, senior attorney, and Terrie A. Rymer, JD, staff attorney, Health Law Division, AMA. Reprinted with permission from *The Citation*, American Medical Association, Volume 59, April 15, 1989)

PROFESSIONAL LIABILITY

James E. George, MD, JD, is the director of the Department of Professional Liability Control, Medical Society of New Jersey. If you have any questions, concerns, or complaints about your professional liability, please address all letters to A. Ronald Rouse, Director of Special Projects, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648. Mr. Rouse also is available at 609/896-1766. Dr. George, an emergency medicine and legal medicine physician, is a member of our Gloucester County component.

We're putting lives back together.

As a physician you've probably seen it. A family's struggle against alcohol or drugs. A man or woman afraid to ask for help in dealing with depression. A young girl hiding an eating disorder behind a smiling face or popular personality.

At the Carrier Foundation, we work with physicians in treating troubled adolescents and adults. Unlike most general hospitals, all our resources are dedicated to this mission. And have been for more than seventy-five years.

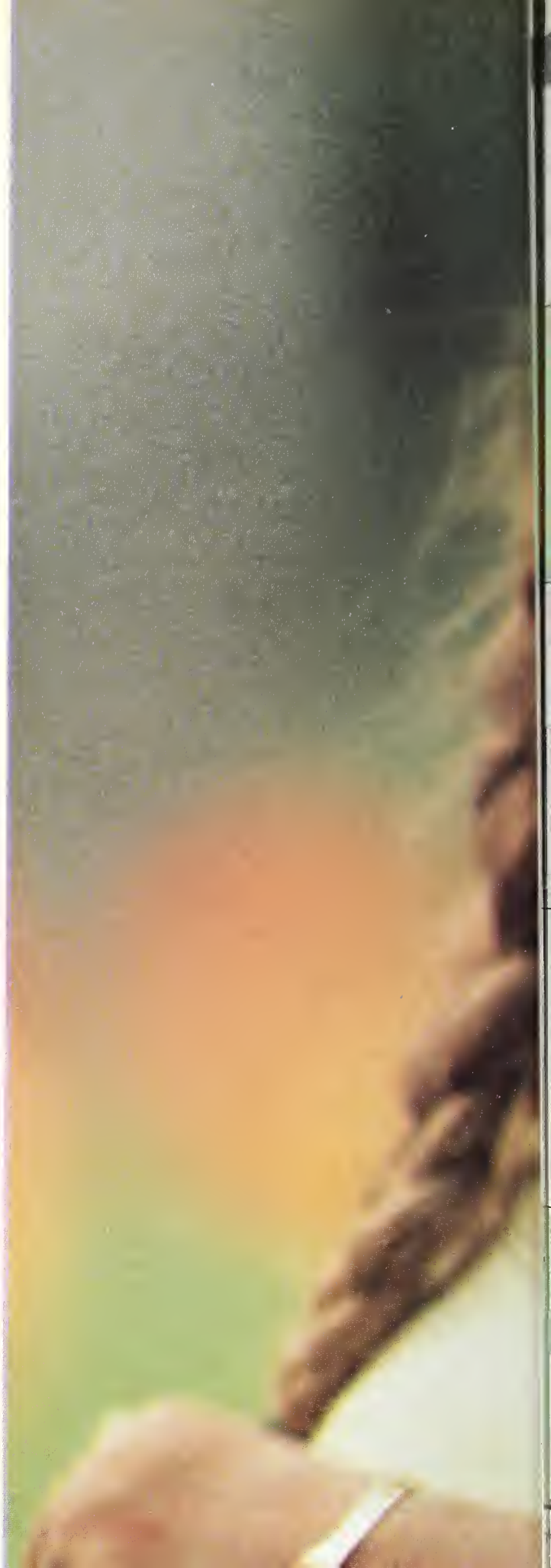
Recognized by all major insurance companies, Carrier is a private, non-profit psychiatric hospital providing both inpatient and outpatient programs. Some of Carrier's specialized programs include: addiction recovery service, adolescent program, affective disorders program, behavioral therapy, eating disorders program, family therapy, geriatric program and women's program.

For more information, call the Carrier Foundation at 1-800-223-0207. The Carrier Foundation. We're putting lives back together.



Carrier Foundation

Belle Mead, New Jersey 08502





MSNJ NEWSLETTER

1990 MSNJ ANNUAL MEETING

The Committee on Annual Meeting voted and the Board of Trustees approved that the 224th Annual Meeting of the Medical Society of New Jersey will be held at the Sands Hotel, Casino and Country Club, in Atlantic City, from Sunday, May 6, 1990, through Wednesday, May 9, 1990. Registration opens at 8 A.M. on May 6, and the House of Delegates first meets at 1 P.M. on that Sunday, and on Monday and Tuesday at 9 A.M. There will be a JEMPAC Political Forum and a Wine and Cheese Reception on Monday, May 7. An inaugural reception and dinner will be held on May 8, at 6:30 P.M. A general session open to all members begins on May 9, at 8:30 A.M. Registration forms are available.

SCHILLER RETIREMENT PLANS

MSNJ is pleased to announce its sponsorship of the Schiller Law Associates retirement plans. As you may be aware, all retirement plans must be revised during the coming months to comply with numerous recent changes in the law. We encourage members to consider utilizing Schiller Law Associates to handle necessary plan changes. It is imperative that these changes be made promptly so that your plans can be submitted to the IRS on a timely basis for their approval. We have arranged for members to have their plans revised at a discounted cost. You will be charged \$995 for one plan or \$1,395 for two plans, including IRS user fees. These rates are up to 50 percent less than others charge for similar services. For a free initial consultation, call David Schiller, JD, LLM (Taxation) at 215/277-5900 (collect).

NEW COMMISSIONER FOR DEPARTMENT OF HUMAN SERVICES

William Waldman, director of the Division of Youth and Family Services, has been named as the acting commissioner of the New Jersey Department of Human Services. Waldman will serve as commissioner for the remaining three months of Governor Kean's term. Waldman takes over a Department with problems. There is an understaffing of the foster care system; a 3,300-person waiting list for community residences for mentally and physically disabled individuals; and a budget shortage to hire needed staff at the institution for the mentally ill and physically disabled. The Department has failed to respond to a notice from HCFA that its physician's fee schedule is so low it threatens continued federal participation in New Jersey.

MARCH OF DIMES THANKS DR. FORMICA

Each year, the March of Dimes presents the Virginia Apgar Award to three New Jersey women of achievement. This year, Dr. Palma Formica was recognized for her outstanding leadership contributions in her community and the field of medicine. In addition to 30 years of internal medicine/family practice, Dr. Formica has founded, directed, and teaches at the Family Practice Center and Residency Program, that is affiliated with St. Peter's Medical Center and the Robert Wood Johnson Medical School. Moreover, the doctor also has demonstrated her leadership abilities as the 1988 president of the Medical Society of New Jersey, as well as the past-president of St. Peter's medical staff, and currently as a delegate to the American Medical Association.

FEDERAL REIMBURSEMENT POLICY

The Hospital Medical Staff Section-New Jersey is sponsoring an educational program on federal reimbursement policy for physicians on November 18, 1989, at MSNJ headquarters in Lawrenceville. Registration opens at 9:30 A.M. and the program adjourns at 12 NOON. For further information, call MSNJ headquarters, 609/896-1766.

HHS ADVISORY COUNCIL

The chairwoman of the 13-member Social Security Advisory Council appointed by HHS Secretary Louis Sullivan, committed to provide recommendations to HHS which would involve wholesale restructuring of the nation's health care system. Deborah Steelman, President Bush's chief domestic policy advisor during the election campaign and health policy leader during the latter part of the Reagan administration, stated "We've got a mess on our hands." She indicated a national health insurance system, recommended by several groups earlier this year, is not the answer because it will "leave underlying mistakes in the health care system in place." The Advisory Council, which is scheduled to deliver its recommendations by July 1990, will address health care problems not only for the elderly, but also for the poor and uninsured.

MEDIGAP POLICIES STILL POPULAR

In a survey conducted by the Health Insurance Association of America, some 500 Medicare beneficiaries reported that over 82 percent renewed their current Medigap Insurance Policies, even though they now qualify for benefits under the Medicare Catastrophic Coverage Act. Eighty percent of those surveyed were satisfied with the benefits of such policies and 70 percent with the cost associated with the policies. Satisfaction with the Medicare program dropped to 70 percent down from 81 percent before catastrophic coverage was introduced. In addition, satisfaction with Medicare premium costs dropped from 74 percent to 30 percent during the same time period. Uncertainty about the level of coverage under the catastrophic coverage law was also high in the survey.

CORPORATE HEALTH CARE COSTS

A study issued by the Health Care Financing Administration's Office of the Actuary, reported that corporate health care costs increased from .5 percent of corporate revenues in 1965 to 1.2 percent in 1987. In 1965, business paid 17 percent of the nation's health care bill of \$38.4 billion. In 1987, the health care bill rose to \$483.2 billion of which business contributed 28 percent. During the same period, an individual's private payment for health care services dropped from 59 percent to 42 percent.

BLUES— INPATIENT DOWN, OUTPATIENT UP

Blue Cross and Blue Shield plans across the country experienced a decrease of 3.4 percent in inpatient admissions per thousand subscribers from 1987 to 1988. Outpatient visits, however, increased 8 percent in the same year.

WILENSKY SELECTED FOR HCFA

Gail Wilensky, economist for Project HOPE, has been selected by HHS Secretary Louis Sullivan, MD, for the role of HCFA administrator. Wilensky is expected to have no problem being approved by Congress. Having previously served in HHS's National Center for Health Services Research, she focused on health care economics and problems of the uninsured. She favors incentives more than federal government regulation and intervention as a solution to controlling health care expenditures. She is highly regarded by the AMA Washington staff.

MEDICARE CUTS TO CONTINUE

According to Richard Darman, the White House budget director, the Medicare budget is growing much too rapidly and needs to be trimmed. Of particular focus, according to Darman, will be physician services where he supports action which would impose annual limits on Medicare payments for such services for 1991 and beyond.

**CATASTROPHIC
BILL DRIVES UP
COSTS**

According to the Health Care Financing Administration and the Congressional Budget Office, the increased coverage for skilled nursing facilities (SNF) under the catastrophic insurance bill has increased Medicare spending for SNF care from \$99 million a month to \$283 million in May. They are projecting SNF Medicare cost to reach \$2.4 billion in 1989, \$2 billion in excess of what was originally estimated to be the cost of the expanded program benefit. Such news certainly puts a damper on the potential for long-term care coverage as a full benefit under Medicare. SNF benefits have been deleted in the current budget mark-up.

**JULY MEDICAL
COST UP**

As usually happens in July, when many hospitals whose fiscal years begin July 1 increase their rates, medical costs jumped .7 percent in July or an annual rate of 7.5 percent for the 12 months ending in July. Room rates were up .8 percent, with overall inpatient prices up 1.2 percent. Outpatient prices rose 1.8 percent and physician services .9 percent.

**GENERIC DRUGS
TO BE CHECKED**

News that some of the nation's drug manufacturers have not been preparing generic drugs according to specifications has caused the Federal Drug Administration (FDA) to begin an immediate program of testing generic drugs. With up to 12 firms making a version of each generic drug, the FDA will test more than 1,000 samples.

**LIVING WILL
BILLS PASS
STATE SENATE**

The New Jersey State Senate narrowly passed two bills that address "living wills" and "brain death." Both Senate bills passed with the minimum number of votes necessary, indicating senators' caution in supporting bills opposed by the Catholic Church and the Right-to-Life Committee. Senate Bill S-3320 would provide legal recognition of "advance directives for health," or "living wills," written by competent adults. Senate Bill S-2659 would recognize brain death as a condition to declare a patient dead. However, if a person's moral or religious beliefs do not recognize brain death, then the traditional criteria of death, where the heart and lungs had irreversibly ceased to function, would be the condition accepted to declare the patient dead. Opponents of the bills feel that both bills could be defeated in the State Assembly.

**ALZHEIMER'S DISEASE
TREATMENT STUDY**

People who suffer from Alzheimer's disease may be eligible for a study of an investigational drug, nimodipine. To be eligible, a patient must be 45 to 85 years old, in generally good health, and have been diagnosed as having Alzheimer's disease. Eligible patients must also be living in the community, not in institutions, and must be reliable about taking medication and keeping appointments. Nimodipine does not cure Alzheimer's disease, but there is some preliminary evidence that it may slow or prevent deterioration of cognitive functions in some patients, though this has not yet been proved. The study is being conducted by the Psychopharmacology Research Association of Princeton. Dr. Jeffrey Mattes, director of the Association, also is clinical assistant professor of psychiatry at the Robert Wood Johnson Medical School. Call Carol LaBracio at 609/921-9299 for further information.

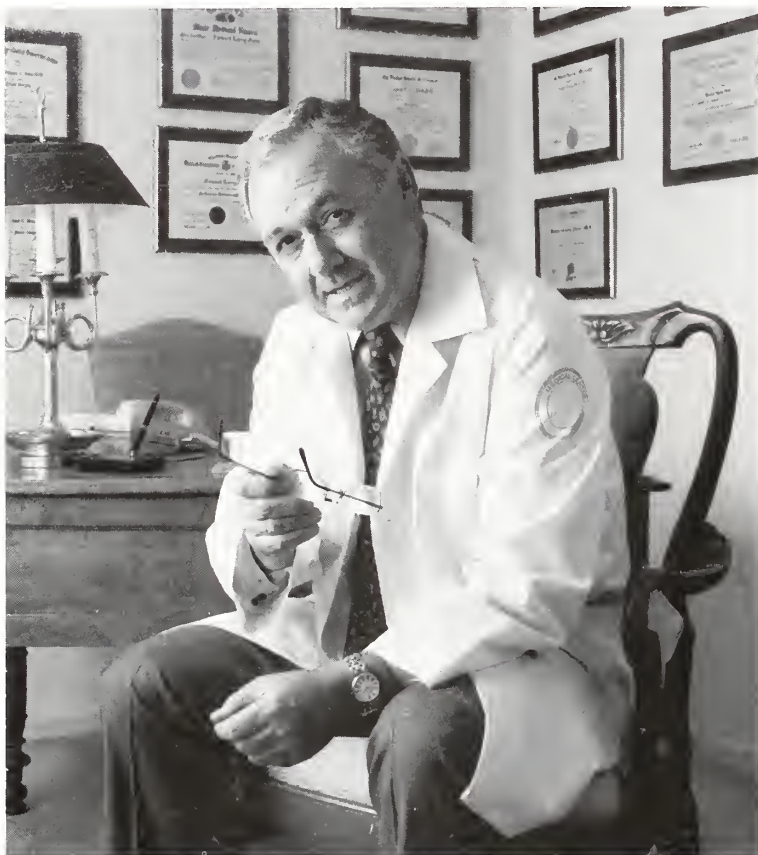
**MEDICAID COVERAGE
EXPANSION
OPPOSITION**

Forty-eight U.S. governors, including Governor Kean, have requested a two-year freeze on any federal legislation that would require states to increase benefits under the Medicaid coverage for pregnant women and infants in families with incomes below 185 percent of the federal poverty level. Health care coverage for all children up to the age of 18 would be phased in over the next few years for families below the poverty level. While the governors do not necessarily oppose improving health care for poor women and children, they do feel that each state should have the flexibility to decide what Medicaid benefits are needed in their states.

FINI

"Those who know the least—know it the loudest."

**“A big insurance company
that’s really listening to me?”**



**I don’t
believe it.”**



PRESIDENT'S PAGE

THE POLITICAL PROCESS

The Medical Society of New Jersey has become increasingly active—aggressively active—in the legislative and regulatory processes that impact on the way you practice medicine, and on the health of your patients. And, when necessary and appropriate, we have followed through with litigation, to defend and secure the rights of our members. We have been compelled to adopt this posture by changes in society. Government now has, and will continue to have, a greater impact on changes in medical care, than all of our research laboratories. We cannot ignore this. We must provide the benefit of our expertise and experience to those molding health policy and public policy.

Participation in the formation of legislation and regulation requires participation in the political process. If you think “politics” is a dirty word, if you feel politics is beneath you, then you never will play a meaningful role in our democratic form of government. The medical profession cannot ignore the forces in our society.

We must play a role, and we will—through meetings with our legislators, by lobbying, and with political action. Many physicians object to the concept of political contributions. But, the political process costs money. If you do not like this idea, remember that many people think it is unseemly for needed medical care to cost money. But we know that doctors have expenses. We know that payment for medical care is not “dirty” but is a necessary part of our system.

Similarly, elections cost money, and the cost cannot be borne by a legislator's salary. This cost (primarily the cost of advertising for a political campaign) is borne by constituents, participants in this democratic process. These contributions are a necessary part of our system, are closely regulated and controlled, and are legal and ethical in every sense. Those who participate cannot necessarily determine the outcome of the process, but by participating, they can affect both the process and the outcome on a regular basis.

If you are offended by these thoughts, then we are lost, and others will determine the form and format of American medical care. But if we participate, we will influence the way government affects medical practice; and we will be working for the betterment of health care in this country on behalf of our profession and on behalf of our patients.

At the recent Board of Trustees legislative seminar, Mr. Richard Altman, the Executive Director of the national PAC, stated that political contributions are “neither moral nor immoral. Just as contributing is a positive act, not contributing is also an affirmative act to a politician.” Mr. Altman further stated that “a contribution of money is a personal right of self-expression, guaranteed by the first amendment.”

A letter from Dr. Edward Bourns on page 855 expresses a contrary viewpoint about political action and PACs. I respect Dr. Bourns, a former MSNJ officer. But, I disagree with his comments. I hope you will, too. The future of the medical profession depends upon it! □

"The ease of operation of the HM-4 for the patient, staff and physician is far superior to the HM-3".

Dr. Joseph S. Ritter
Summit, NJ



"The location; the ease of the valet parking; the decor; and the way the patients are cared for—the response has been favorable".

Dr. Franklin Morrow
Roselle, Rahway, NJ



"The Stone Center is a first class operation starting from the receptionist at the front desk, through the nursing staff and technicians to Arlyn (R. Arlyn Rayfield, Executive Director)".

Dr. Patrick N. Ciccone
Belleville, Livingston and
West Patterson, NJ



WAVE REVIEWS

Why the accolades?

Over the past year we've successfully treated more than 1500 patients. And with over 100 affiliated urologists on staff, we asked a few to share their thoughts on our Center.

Perhaps their comments come from knowing that their patients were treated in a sophisticated atmosphere by the state's top lithotripsy professionals.

Or perhaps, it's the extra efforts we make to ensure that our physicians and patients are happy, such as...

- providing a patient representative who will schedule your cases for you and make sure all of your special requirements are taken care of.
- our Physician Referral Service, which provides prospective patients with the names of affiliated physicians located in their geographic locations.
- our convenient valet parking.
- our new expanded hours (6:30 AM - 7:00 PM) and Saturday availability.
- our physician newsletter, created to keep you abreast of the latest technology, events and occasions at The Stone Center.

If you are not familiar with The Stone Center, contact Arlyn Rayfield, Executive Director, today, and schedule an appointment for machine demonstrations or to receive additional information on ESWL® treatment.

Your patients will thank you for it.



150 Bergen Street
Newark, New Jersey 07103-2425
(201) 456-4765

...for the new wave in kidney stone treatment.

The Stone Center is northern New Jersey's only certified lithotripsy facility -- therefore the procedure is supported by most medical insurers.



EDITOR'S DESK

PEER REVIEW, PART I

The First International Congress on Peer Review in Biomedical Publications was held in Chicago from May 10 through May 12, 1989. Yours truly was privileged to attend, along with almost 200 other interested parties from around the world.

The experience was daunting, to say the least. We were inundated by a sea of professors, editors, statisticians, investigators, and administrators, representing the most prestigious publications and organizations in the Western world—the ones cited in major newspapers and magazines and documented on network television. One felt like an adolescent schoolboy, scribbling away for eight hours a day, with occasional coffee breaks, in order to catch all the pearls and to digest even the crumbs regurgitated by these fonts of publication wisdom, whose subscription numbers sometimes reach six figures.

But we sat, and listened, and listened, and began to understand that old verities still apply: little children (or publications), little problems; big children, big problems—this applying mainly to peer review. The problem of erroneous and fraudulent reports was discussed at length. This, of course, was a subject with which the media had a field day. The *Washington Post* headlined, "The Public's Perils of Publishing; Medical Journals Need Quality Control." *The New York Times*, in slightly more temperate style, announced, "Errors Prompt Proposal To Improve Peer Review At Science Journals," adding, "The review system is poorly understood by most physicians and scientists." It is clear that papers published by the larger journals, such as *The New England Journal of Medicine* and *The Journal of the American Medical Association*, receive the quickest and the most intense dissemination by the media; they, therefore, influence public opinion greatly and carry the most potential for harm, should the data prove false. This was well recognized by those attending the conference and the need for careful review and methods to accomplish this were dissected and analyzed to a fare-thee-well.

Although its staff and its circulation may be miniscule compared to other journals, *NEW JERSEY MEDICINE* has a review process which duplicates, on a smaller scale, the ones employed by the largest periodicals. The news items from the Medical Society of New Jersey are not challenged nor revised before publication. "Letters to the Editor" and proposed advertising are given internal review. All scientific manuscripts are reviewed (or refereed), usually by two, occasionally by three or more, members of the Publication Committee, the Editorial Board, or our consulting staff. The editors then give the final review and decide to publish (with or without revision), to publish as a priority, to return for revision (or rewriting, as we require too frequently) and reconsideration, or to reject. Those papers that are revised (or rewritten) and returned, once again, are subjected to review, although fewer referees may be used, and to final disposition by the editors. Authors of rejected articles have the prerogative to disagree with the expressed reasons for rejection and to have further consideration.

The editorial review process of *The New England Journal of Medicine* is carefully outlined by Drs. Relman and Angell, editors, in their September 21, 1989, issue. We recommend your perusal of these editorials. A comparison of their methodology with ours demonstrates much more similarity than difference, despite the vast disparity in the volume of work and the number of involved reviewers. [We wish you, our readers, could help to narrow the gap in the amount of work reviewed, by increasing the number of your papers to *NEW JERSEY MEDICINE*.] Dr. Relman and Angell also discussed the problem of scientific fraud. There is no easy solution; maximum vigilance cannot stop the truly dedicated and determined villain, but it can help and must be continued.

The Congress on Peer Review considered many items other than the ones noted above. Many topics discussed by the panel, and debated pro and con, also may be worth our deliberations. They will be presented to the Publications Committee and to the Editorial Board with the expectation that they can provide a stimulus for the continued growth and improvement of *NEW JERSEY MEDICINE*.

As noted earlier, too many manuscripts are returned for rewriting, often extensive in scale. To aid those contemplating authorship, let me plagiarize some of the comments expressed by Malcolm Bradbury in the magazine section of *The New York Times* (September 24, 1989). He wrote of the "Six Gross Illiteracies . . . that earned an automatic 'F' on any student theme." Two that most commonly are seen are:

Violation of Fundamental Concord of Agreement. ("Many a successful corporation president owes their success to our efforts.")

Dangling Modifier. ("If thoroughly stewed, the patients will enjoy our prunes.")

So please, watch your singulars and your plurals, and take care with your modifiers. But keep your contributions coming. □

OBSTETRICIANS' DILEMMA

The article by Halpin and colleagues on pages 867-873 raises an important issue to all physicians. There is general concern among health care practitioners and administrators that the rate of cesarean section delivery may be too high. Unfortunately, not all of this concern is based on the patient's welfare. The increased cost and length of hospital stay associated with cesarean delivery is a major concern to many persons.

What is the ideal cesarean section rate? It is one that assures the optimum number of women will be delivered of a healthy child by a route of delivery that is most appropriate. In short, no one knows.

Dr. Halpin's article focuses on an important issue. To quote the author, James Baldwin, "Not everything that is faced can be changed, but nothing can be changed unless it is faced." Physicians will do their part in controlling operative delivery by peer review and continuing education. Society must do its part by providing adequate nursing personnel, monitoring equipment, and providing other resources so the obstetrician may make the decision to perform or not to perform cesarean section based on factors other than "difficulty in getting to the operating room unless I go now," or "I have no way of evaluating how the infant is tolerating this labor." It would help if we were aware that most cases of cerebral palsy are not due to events that coincide with the labor process.

Obstetricians will apply their efforts to obtain an appropriate cesarean section rate. They will not focus on a "good number" but rather on a good outcome for their patients. □ Gerard F. Hansen, MD, President, New Jersey Obstetrical and Gynecological Society



BOOK REVIEWS

ANNUAL REVIEW OF MEDICINE

William P. Creger. Palo Alto, CA. Annual Review Inc., 1989. This, the 40th volume of a well-known series of publications, is a collection of excellent discussions of specific subjects. There are 37 different topics and each one of them represents a valuable source of information for the practicing physician. I enjoyed the discussion on operations for duodenal ulcer disease, anticoagulants during pregnancy, cocaine dependence, mitral valve prolapse, liver transplantation, and sarcoidosis. These volumes are excellent reviews and written in clear and concise ways; I highly recommend their reading to any internist dealing with the subjects outlined on the contents pages. □ Geobel A. Marin, MD

DIAGNOSTIC IMMUNOPATHOLOGY

Robert B. Colvin, MD, Atul K. Bhan, MD, Robert T. McCluskey, MD (eds). New York, NY, Raven Press, 1988. The intention of this text was to provide a practical and critical analysis of the performance and interpretation of current immunological tests performed in diagnostic pathology laboratories. In addition, the editors attempted to create a framework for the analysis of immunopathologic processes. This textbook more than adequately meets those stated purposes. The contributors are experts in the field of diagnostic immunology as it applies to surgical pathology. This textbook should present itself as a standard reference work next to all pathologists' general pathology texts and surgical pathology review texts. The method in which the authors divided the text is practical and applicable to the daily workload of the surgical pathologist. The chapter on immunological techniques is well done. The application of these methodologies in a differential diagnosis of surgical pathology diagnostic problems in the area of tumor diagnosis also is very well done. The authors open the door to evolving surgical pathology techniques in the areas of immunofluorescence, immunoperoxidase, flow cytometry, and in situ hybridization techniques. This text is a standard, and probably will be updated to keep pace with the implementation of newer techniques and diagnostic surgical pathology and immunopathology. The chapters of the textbook cover immunopathological diseases and neoplasia. The areas of neoplasia particularly are done in depth to give the reader an excellent opinion of the usefulness of the immunohistochemical techniques in supporting the light microscopic diagnosis of tumor type. □ William V. Harrer, MD

JURY OF MY PEERS

Howard C. Snider, Jr, MD. Greenwood, FL, The Penkevill Publishing Company, 1989. Pp. 292. In this book, the author takes us on a painful journey with him as a medical malpractice defendant through the legal system. Dr. Snider shares his opinion that medical malpractice lawsuits have no place in the jury system—and never did. To drive his point home, he quotes Mark Twain: "The jury system puts a ban upon intelligence and honesty, and a premium upon ignorance, stupidity, and perjury. It is a shame that we must continue to use a worthless system because it was good a thousand years ago."

The author skillfully describes his feelings from notification of suit, pretrial discovery, and courtroom litigation, all the way through final

jury verdict for the defense, the plaintiff's motion for a new trial, de of that motion, and ultimate forfeiture of the right to appeal. The au candidly admits that, when the trial was over, he was "unable to sin walk away from it." Although he won the case, Dr. Snider paid a s emotional price for the victory. This emotional fervor provided energy necessary for the physician-author to interview the jurors, tempt to interview one of the expert witnesses against him, and, fine to write this interesting book! Although one may differ with the auth opinion about the jury system, *Jury of My Peers. A Surgeon's Encoun with the Malpractice Crisis* is well written and provides worthw reading for even the busiest physician. □ James E. George, MD,

MEDICAL TESTS AND DIAGNOSTIC PROCEDURES

H. Winter Griffith, MD. Philadelphia, PA, Lea & Febiger, 1989. T first edition is a collection of perforated/looseleaf pages with 405 differ laboratory tests, constructed as instruction sheets to be given to t patient to take home, read, and study. Each page gives a descripti of a test, the methods of collecting the specimen, test results to expected, normal or abnormal values indicated, and drugs affecting interfering with test results and post-test care. The rationale for tl teaching method is that patients should know and comprehend why t physician wants certain tests. Also, third-party payers would agree th these are good patient teaching tools.

Future editions are expected, and should accommodate needs for p tients who are fluent in languages other than English; also needed a simpler explanations of many test-interfering medications. For exampl prescription bottles at home may have many variable trade, generic, other names for acetylsalicylic acid, otherwise known as aspirin. The are many other medications named on each page. Generally, physicia would request a complete blood or urine test, either fasting or nonfastin There are over 42 pages on singular urine tests and at least twice th number on singular blood tests, which are exceptions to the gener patients needs. Some of these may be consolidated.

Dr. Griffith has a good idea, with good intentions with *Medical Tes and Diagnostic Procedures*, but further editions should consider change in format for brevity, clarity, and simplicity in the explanatory section □ Harry M. Poppick, MD

OTOLARYNGOLOGY. HEAD & NECK SURGERY

Charles W. Cummings, MD (ed). St. Louis, MO, The C.V. Mosb Company, 1989. This text is an otolaryngology update, filling the need for a contemporary text in this specialty. The book basically is geared toward otolaryngologists, but I would recommend it wholeheartedly t every pediatrician, internist, and family practitioner.

The strong point of the book is that it is divided in three sections; th first unit covers newer diagnostic imaging. As in all parts of medicine CT scans and MRI constantly are being updated. There is another section on therapeutic management and operative developments reveal ing the newer surgical techniques that are available in this specialty There is an especially good chapter on endoscopic sinus surgery, one of the newest modalities in sinus surgery—the first great improvement to come along in many years. The third section on clinical entities is extremely important, with excellent chapters on acquired immune defi ciency syndrome in otolaryngology, sleep apnea disorders, and manage ment of otitis media.

In conclusion, this book certainly belongs on the shelf of every practicing otolaryngologist to be referred to again and again. □ Harold Arlen, MD



LETTERS & VIEWPOINTS

PHYSICIANS AND POLITICS

Since June 8, 1989, these thoughts have been whirling through my mind. They concern AMPAC and JEMPAC. Although the effect may be like shooting boiled peas at a battleship, I'll take this shot at entrenchment.

I do not believe PACs are morally right. Like all PACs, JEMPAC attempts to buy influence. Even if that is the way politics veers, it is off course for us and demeaning to us as physicians. Why are we any different from Jim Wright in buying and selling favors?

"Hey now, Red, ease up, get your head out of the clouds, as Ann Landers says; wake up and smell the coffee." Well, I smell it and it is stale. My head may be in the clouds but my feet are firmly on the ground. I do not hear any urging to get the PACs incorporated into the Hippocratic oath. Maybe we are heading toward a change in spelling of the oath?

I would appreciate a constructive reply which would enable us to get out of this political slough and appear a bit above the teamsters' union (see page 845). □ Edward G. Bourns, MD

PHYSICIAN COMPASSION

Dr. Richard Fadol's letter from a patient's son (July 1989) focuses attention on the bedside relationship between surgeon and patient. Like seed and soil, the combination may not always be right, even with merit on both sides.

Some facts quickly are noticeable—there was no internist on the case to help the surgeon. Often internists are better listeners and take more time, because attention to detail is the hallmark of the well-trained physician, emotional factors included. This observation does not slight surgeons; it recognizes that their primary arena of operations is different. It is a wise surgeon who will recognize the need for emotional support and call an internist to help him. The hospital has a social service agency and clergy on call as well. In this instance, the surgeon did not recognize the need until the letter from the patient's son arrived. The patient felt, rightly or wrongly, that the surgeon did not wish to listen, so he did not "open up" to his doctor, but complained to his son. Notice that the surgeon did not share care of the patient with anyone.

Here are two maneuvers that a busy surgeon can use today to help him deal constructively with the patient who wants to talk when he has no time to listen. He can shake hands with the male patient or hold hands for a moment with the elderly female patient—the value of which cannot be underestimated, as holding hands is the essential symbol of emotional support—and tell the truth, "I can't spend much time with you now," but I will call you after supper on your bedside phone to talk and I want to know what you ate for supper." And, do it.

The surgeon then meets his operating room schedule unhurried, calls the patient back between 6 and 7 P.M. for a few moments of listening and has shown the patient that he is truthful, human, and interested. This is a bridge of support that the surgeon has built himself.

The next morning's rounds will be easier, since the problems have been

outlined on the phone, and he has told the patient, "We'll talk me about that when I see you tomorrow morning." The surgeon can call others to help him, as noted above, if required.

The second procedure, also simple, has helped me tremendously to build rapport with families, with the effect that shines on the patient as we call the family before they call you. This is most important in preventing conflicts from building up to explosive proportions and an angry unknown relative on the telephone. One introductory phone call, especially from the patient's bedside, will do wonders in relieving the guilt feeling of children out of town, and the apprehensions of others. They often will tell you what is worrying the patient, which brings us back to the patient in Dr. Fadil's eloquent letter. □ Morris Soled, MD

Editor's Reply. We thank Dr. Soled for sharing the wisdom that years of experience can provide. Unfortunately, all medical disciplines, not just surgery, have practitioners who fail to listen—truly listen—to the patient, particularly when the patient is expressing silent emotions.

Compassion is the name of the game. We hope others, besides Dr. Soled, can appreciate the letter from Dr. Fadil and benefit from it.

PEDIATRIC HEMATOLOGY/ ONCOLOGY

The New Jersey Pediatric Hematology/Oncology Network (NJPHON) is a professional organization comprised of board certified pediatric hematologists/oncologists and their support staffs who treat the bulk of cancer patients at seven childhood cancer centers across New Jersey. NJPHON and public health researchers at the Department of Urban Studies and Community Health at Rutgers University agreed to put together a database on pediatric cancer in the state that could be used for basic epidemiologic research. The New Jersey State Department of Health has cooperated with Rutgers and NJPHON by providing the currently available data for cases 0 to 21 years of age on the Cancer Registry Analytic File for the years 1979 to 1986. These data were provided for active case finding and verification only, with the expressed purpose of creating the best database possible for future pediatric cancer research.

The research team in New Brunswick, NJPHON members, data managers, and the tumor registrars at NJPHON hospitals, the staff of the Greater Delaware Valley Pediatric Tumor Registry, cooperating New York hospitals, and the staff of the New Jersey Cancer Registry worked together on this project. The final report on their efforts was released in July 1989, and states that once cases located are added and minor corrections made, New Jersey will have a database on childhood cancer which includes at least 90 percent of all pediatric cases for the year under study.

This is good news for all those involved in this effort. The project pulled together public health academics and a professional organization of clinicians, along with the State Department of Health. It was a highly worthwhile effort, as the results show that researchers can have confidence in the State Cancer Registry's pediatric data, and that future projects can be done in a cooperative environment. NJPHON looks forward to the Cancer Registry's completion of database additions and corrections so that its original desire to pursue epidemiologic research on the childhood cancer incidence in New Jersey can begin. Future cooperative efforts such as this can only help New Jersey take the lead in addressing one of our public health problems—that of childhood cancer. □ Dona Schneider, PhD; Michael R. Greenberg, PhD; Milton H. Donaldson, MD

Cytological Diagnosis of Breast Cancer

ANIS F. RANGWALA, MD
MAGALY PEREZ-BLANCO, MD
JANE REILLY, CT

One hundred thirty-one fine-needle aspirations and 85 nipple discharge smears were evaluated cytologically and correlated with histological diagnoses and with clinical impressions. This study demonstrates that cytological diagnosis of breast lesions is a useful and clinically accurate procedure.

Breast carcinoma is a leading cause of death in women. The need for early diagnosis to detect minimal or noninvasive disease cannot be overemphasized. The diagnosis of breast cancer by fine-needle aspiration biopsy has great promise to achieve this goal. Since 1930, when Martin and Ellis introduced the technique of needle aspiration,¹ numerous authors have published their experiences to demonstrate its value.²⁻¹² The purpose of this retrospective study is to evaluate the accuracy of fine-needle aspiration of the breast and nipple discharge smears in the diagnosis

of breast cancer at Monmouth Medical Center, Long Branch, and to compare the results with those published in the literature.

MATERIALS AND METHODS

We reviewed all the breast cytology specimens submitted to the Department of Pathology at Monmouth Medical Center from January 1983 to December 1985. Of the 216 cases, 131 cases were fine-needle aspiration biopsies and the remaining 85 cases were nipple discharges. In addition, 62 (47.3 percent) of the fine-needle aspirations and 16 (18.8 percent) of the nipple discharges had subsequent histological evaluation of the breast lesions.

The material was obtained from 198 patients (197 females and 1 male); ages ranged from 17 to 87 years with a mean age of 47 years.

The fine-needle aspiration material was received in the cytology department in 50 ml tubes containing

Dr. Rangwala is associate pathologist, Dr. Perez-Blanco is senior pathology resident, and Ms. Reilly is supervisor, section of cytology, Department of Pathology, Monmouth Medical Center. Requests for reprints may be addressed to Dr. Rangwala, Department of Pathology, Monmouth Medical Center, 300 Second Avenue, Long Branch, NJ 07740.

sterile saline. Ninety-five percent ethyl alcohol is added to the tubes which are centrifuged at 1,500 rpm for 20 minutes and the supernatant is discarded. The spun cellular material is used to prepare two to four smears. If the aspirate is composed of a substantial amount of cellular material, the sediment is divided into two equal parts and a cell block is prepared in addition to the four smears. The smears are fixed in 95 percent ethyl alcohol for 30 minutes and stained using a modified Papanicolaou procedure. Aspirated liquid from cystic lesions is centrifuged and the sediment is treated in the same fashion. The nipple discharge smears are submitted to the laboratory directly from physicians' offices already fixed in 95 percent ethyl alcohol and then stained by the above method.

The cytology smears were recovered from our patient files and independently screened by a senior cytotechnologist and interpreted by a pathologist experienced in cytopathology. Other information received included age and clinical diagnosis.

The cytological diagnoses were as follows: scant or insufficient for diagnosis; benign, fibroadenoma; benign, fibrocystic; benign, other; atypical; suspicious for malignancy; and malignant. The cytological diagnoses then were correlated with tissue diagnoses of those cases that subsequently had open biopsies. Medical records of patients without tissue diagnosis were reviewed to determine their current status.

The histological diagnoses were the following: benign, fibroadenoma; benign, fibrocystic; benign, other; noninfiltrating carcinoma; and infiltrating carcinoma.

Results were tabulated and sensitivity, specificity, accuracy, predictive value of a positive result, and predictive value of a negative result were calculated. In order to obtain these values, the following formulas (TP-true positive; TN-true negative; FP-false positive; FN-false negative) were used:

a) Sensitivity (the probability that the test be positive when the disease is present):

$$\frac{TP}{TP + FN} \times 100$$

b) Specificity (the probability that the test be negative when the disease is absent):

$$\frac{TN}{TN + FP} \times 100$$

c) Positive predictive value (the probability that the disease is present when the test is positive)

$$\frac{TP}{TP + FP} \times 100$$

d) Negative predictive value (the probability that the disease is absent when the test is negative)

$$\frac{TN}{TN + FN} \times 100$$

e) Accuracy:

$$\frac{TP + TN}{TP + FP + FN + TN} \times 100$$

Only patients diagnosed as positive were considered positive and patients diagnosed scant/insufficient, benign, atypical, and suspicious were considered negative.

The cytological criteria used were as follows:

1. **Scant or insufficient for diagnosis:** Report on smears with very scant, absent cellular elements or those containing only blood.

2. **Benign, fibroadenoma** (Figure 1): Represented by clusters of benign epithelial cells in tight cohesion, abundance of single bare nuclei (called sentinel nuclei) and some fibroblastic cells with occasional branching mixed with the epithelial cells.

3. **Benign, fibrocystic** (Figure 2): Cases showing the following features: benign duct cells, apocrine

Table 1. Summary of cytologic and histopathologic diagnoses.

Cytologic diagnosis	Not Done	Histopathologic Diagnosis					Total
		Benign, Fibroadenoma	Benign, Fibrocystic	Benign, Other	Non-Infiltrating Carcinoma	Infiltrating Carcinoma	
Scant/insufficient	12 (5.5%)	2 (0.9%)	11 (5.1%)	5 (2.3%)	1 (0.5%)	3 (1.4%)	34
Benign, fibroadenoma		7 (3.2%)	2 (0.9%)	1 (0.5%)			10
Benign, fibrocystic			12 (5.6%)	2 (0.9%)			14
Benign, other	125 (57.9%)	2 (0.9%)	9 (4.2%)	9 (4.2%)		1 (0.5%)	146
Atypical	1 (0.5%)		2 (0.9%)	1 (0.5%)	1 (0.5%)		5
Suspicious					1 (0.5%)	1 (0.5%)	2
Malignant						5 (2.3%)	5
Case Totals	138	11	36	18	3	10	216

Table 2. The value of aspiration cytology in the diagnosis of breast lesions. Review of the literature.⁺

Authors	Years of Study	No. of Cases	FP	FN	S%	SP%	PPV%	NPV%	Accuracy %
Jela, et al. ² Paris, France 1975	18	2,772	3 (0.1%)	117 (4.2%)	93	100	100	89	95
Czek, et al. ^{3*} Stockholm, Sweden 1967	8	1,200	0 (0.0%)	166 (13.8%)	75	100	100	77	86
Johnson, et al. ^{5*} Boston, MA 1978	5	332	2 (0.6%)	31 (9.3%)	35	99	90	90	90
Henners, et al. ⁶ Philadelphia, PA 1985	2	185	0 (0.0%)	23 (12.4%)	78	100	100	78	88
Wang, et al. ^{4**} Los Angeles, CA 1979	3	161	0 (0.0%)	48 (29.8%)	48	100	100	59	70
Agwala, et al. New Jersey Branch, NJ 1987	3	78	0 (0.0%)	8 (10.3%)	38.5	100	100	89	90

FP = false positive; FN = false negative; S = sensitivity; SP = specificity; PPV = positive predictive value; NPV = negative predictive value.

* "Insufficient" or "unsatisfactory" smears are included in the benign category.

** "Insufficient" diagnoses not given.

† This Table includes only those cases which were verified by histology.

metaplasia, evidence of fluid component seen as a precipitate on the smear background, foam cells, and inflammatory cells. Benign duct epithelium alone is not diagnostic of fibrocystic disease, but frequently it is found as the only component. Foam cells (Figure 3) usually are found in cyst fluid. They are thought to be of duct epithelial origin and have the appearance of foamy macrophages. They show uniform small nuclei and ample vacuolated cytoplasm. The metaplastic apocrine cells (Figure 4) are seen as monolayer sheets or papillary clusters of rounded cells with abundant dense cytoplasm with protruding at the border. The nuclei also are round with clumped chromatin and may show mild anisonucleosis. Inflammatory cells sometimes are prominent, and multinucleated giant cells also may be seen. Patients with marked fibrosis as one of the fibrocystic changes may reveal scant cellularity.

4. Benign, other: Conditions include: papilloma, papillomatosis, lipoma, fat necrosis, mastitis, lactational changes, and only benign duct epithelium. The benign duct epithelium (Figure 5) is composed of small epithelial cells in tight sheets or clusters, sometimes with honeycomb arrangement. The nuclei have bland or slightly granular chromatin with minimal or no anisonucleosis and scanty, ill-defined cytoplasm. Benign papillary clusters (Figure 6) of epithelial cells with flattened cells at the periphery are characteristic of papilloma, papillomatosis, and papillary epithelial hyperplasia. Occasionally, the nuclei of the peripheral cells show a crescent shape and vacuolation. Atypical features noted include increased anisocytosis and pleomorphism. Adipose tissue

(Figure 7) appears as superimposed large polygonal cells with intersecting fibroblasts and capillaries. Fat cells may be the only finding in cases of lipoma or in inadequate aspirations of a fibrotic or sclerotic mass. In cases of mastitis and abscess, inflammatory cells may predominate.

5. Atypical: Reported on smears showing cohesive clusters of cells with only mild variation in size and shape and slight nuclear hyperchromasia. Reactive or degenerative atypia can be seen in cases of fibrocystic disease, usually affecting the cyst lining epithelium. Also, atypia sometimes is seen in papillomas. In these cases, the atypical features are focal.

6. Suspicious for malignancy: Presence of few markedly atypical cells without the constellation of malignant features described below.

7. Malignant (Figure 8 and 9): Criteria to diagnose malignancy are a considerable number of pleomorphic epithelial cells, individually and in clusters, with nuclear enlargement; heavy irregular chromatin; hyperchromasia; prominent nucleoli; severe anisocytosis; and anisonucleosis.

RESULTS

The results of 216 fine-needle aspirations and nipple discharges of the breast are summarized in Table 1. Of the 216 cytologic diagnoses, 34 diagnoses (15.7 percent) were classified as scant/insufficient for diagnosis; 170 diagnoses (78.2 percent) were reported as benign; 5 diagnoses (2.3 percent) were reported as atypical; 2 diagnoses (0.9 percent) were ranked suspicious for malignancy; and 5 diagnoses (2.3 per-

cent) were malignant. Within the total of 216 cases, 138 cases did not have histologic evaluation. This group was composed of 125 benign, other; 12 scant or insufficient; and 1 atypical. On review, this atypical case was a breast cyst aspiration with complete resolution of the cyst and without symptoms for more than a year.

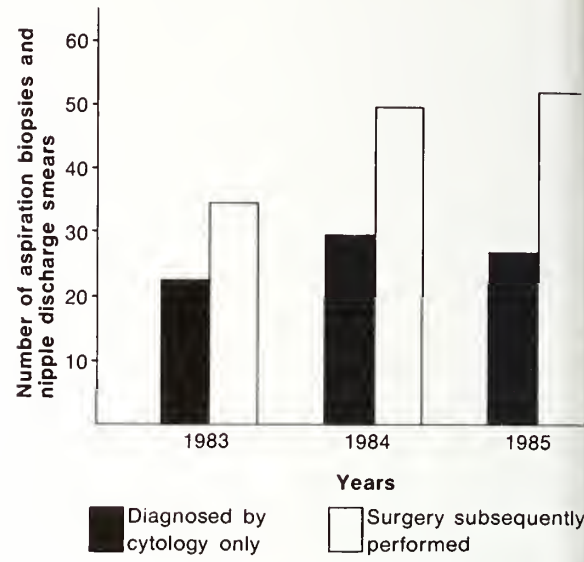
Seventy-eight patients had biopsy and histopathological evaluation. Of this group, 65 cases had a tissue diagnosis of benign disease (fibroadenoma, fibrocystic disease, or other) and 13 cases were reported to be malignant. Of the 65 benign cases, 44 were classified cytologically in the benign category; 3 cases were atypical, and 18 cases were diagnosed as scant or insufficient. The 3 cytologically atypical cases were reviewed and the tissue showed fibrocystic disease in 2 cases and papilloma in the other case. Atypical ductal hyperplasia was seen in the cases of cystic disease and papillary proliferations were noted in the papilloma. There was not a single case in this group diagnosed by cytology as malignant. Therefore, there are no false-positive diagnoses in our series.

Of the 13 tissue-proved malignancies, 5 cases were classified as malignant by cytology; 4 cases were diagnosed as scant/insufficient for diagnosis; 1 case was benign; 1 case was atypical; and 2 cases were suspicious for malignancy. Therefore, only 8 cases were considered false-negative for statistical purposes including the scant/insufficient cases.

Review of the false-negative smears revealed the following: 1) In the cases reported scant/insufficient for diagnosis, the smears showed very scanty cellular material with two smears showing only blood. 2) The case reported "benign, other" by cytology showed few epithelial clusters of perfectly benign ductal cells. The histologic diagnosis, however, was infiltrating duct and intraductal carcinoma. 3) The false-negative case reported atypical was a nipple discharge showing only a few slightly enlarged and hyperchromatic epithelial cells but had a tissue diagnosis of infiltrating duct carcinoma. 4) The two cases diagnosed suspicious by cytology also were nipple discharges and these smears showed few hyperchromatic epithelial cells, however, other features of malignancy were not present. Both cases had tissue diagnosis of intraductal carcinoma. In the atypical and the two suspicious cases, all the criteria for malignancy were not present. The cellularity in these cases was less, the nuclear criteria of malignancy including heavy and irregular chromatin, nucleoli, and thick irregular nuclear membrane were not distinct.

None of the false-negative cases could be considered positive, indicating that the smears apparently were not representative of the lesions and therefore, were attributed to sampling errors.

Table 3. Frequency of aspiration biopsy of the breast and nipple discharge smear 1983 to 1985.



Statistical findings in this series were: 5 true positives, 65 true negatives, 8 false-negatives, and 0 false-positives, which yielded a sensitivity of 38 percent, a specificity of 100 percent, a predictive value of a positive result of 100 percent, a predictive value of a negative result of 89 percent, and diagnostic accuracy of 90 percent.

DISCUSSION

Aspiration biopsy is a procedure by which cellular material is drawn into a needle by negative pressure created by a syringe. The cellular material is composed of epithelial cells mixed with interstitial fluid and some blood, and, frequently, it is semisolid.

The technique can be applied to many sites throughout the body,¹³ and it has been used extensively for the female breast. Frable has found that fine-needle aspiration smears of the breast are the most difficult to interpret and, therefore, a conservative approach, even if it yields relatively high false-negative results, should be followed in medical centers where definite treatment may be performed on the basis of aspiration cytology.¹⁴

Aspiration diagnosis should be correlated with the clinical information and impression, and the following protocol can be used: a) If the clinical and/or mammographic impression is that of a cyst or benign tumor and the aspiration cytology is negative, then this cytologic procedure can save an admission, give extra time to schedule a "lumpectomy," or obviate the need for a frozen section. If the clinical impression is that of a malignant tumor and the aspiration cytology diagnosis is benign, inadequate, atypical, or suspicious, a repeat

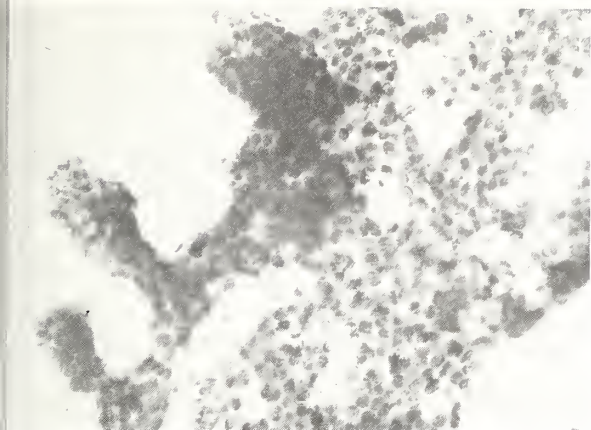


Figure 1. Fibroadenoma. Note duct cells in tight cluster (Papanicolaou stain x 400).

aspiration or a surgical biopsy with frozen section is warranted. c) If, on the other hand, the cytology is positive, there is no need for frozen section.

Table 2 shows a comparison of data collected from several published studies and our present series. The results confirm the high specificity and predictive values of a positive result, since false-positive results are seen to be consistently very low.

The atypical and suspicious cases have been classified in the negative category for statistical purposes because these cases demand further investigation before any definitive therapeutic action can be taken.

No false-positive diagnoses were made in our series, and only infrequent false-positive diagnoses, ranging from 0 to 0.6 percent, are reported in the literature (Table 2). Causes for this type of error are either reparative or degenerative atypia, misinterpretation of drying artifacts and foreign body reactions. These difficulties of interpretation can be mastered with experience.

Table 2 also shows the false-negative diagnoses ranging from 3.2 to 29.8 percent. Our study compares favorably with only 10.3 percent false-negative cases and 89.4 percent concordance between histology and cytology.

There are three causes of false-negative diagnoses. One cause of this diagnosis is sampling error, which includes small lesions, deeply located tumors, aspiration in area other than tumor, poor cellular yield due to tumor fibrosis, and carcinoma in the vicinity of a benign cyst. If a mass persists on palpation after aspirating cyst fluid, a second aspiration could be performed in two to three months. 2) Defective smear preparation is another cause, since diagnostic material may be distorted and impossible to be recognized. The smear preparation is perfected through practice and experience and the cytotechnologists are in the ideal position to achieve this goal. 3) A third reason for false-negative diagnoses is cytotechnologist screening errors. 4) Pathologist

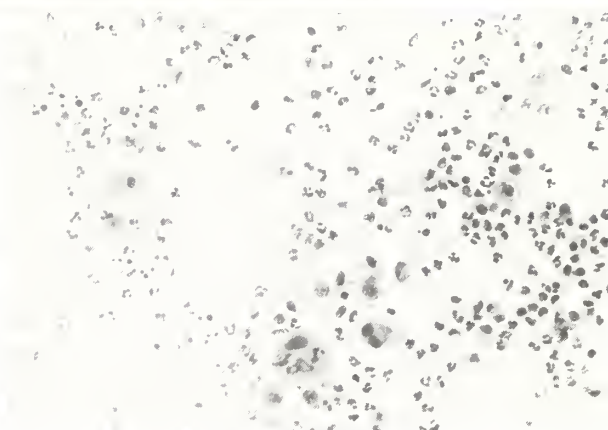


Figure 2. Fibrocystic disease. Note an isolated apocrine cell surrounded by foam cells and inflammatory cells (Papanicolaou stain x 400).

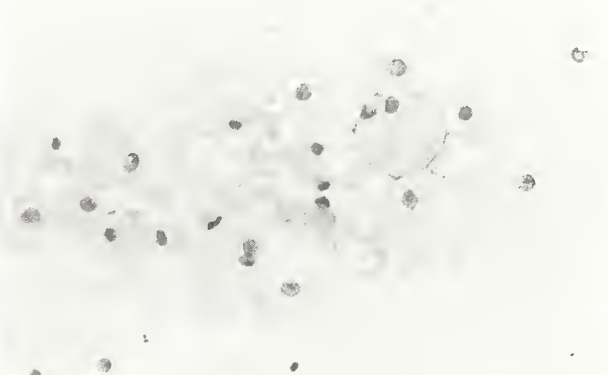


Figure 3. Foam cells. The nuclei are centrally or eccentrically located and there is abundant vacuolated cytoplasm (Papanicolaou stain x 400).

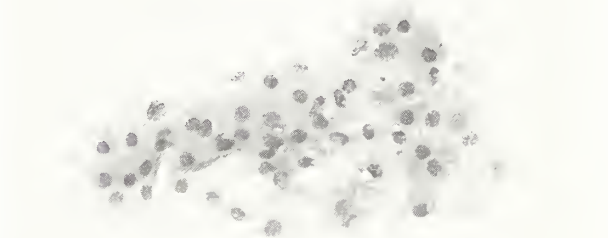


Figure 4. Apocrine metaplasia. Note cluster of cells with rounded contours and abundant dense cytoplasm (Papanicolaou stain x 400).

misinterpretation and judgment errors are other reasons for false-negative diagnoses.

If there is clinical suspicion of cancer, a negative result should be disregarded and additional investigation conducted.

The incidence of inadequate smears ranges from

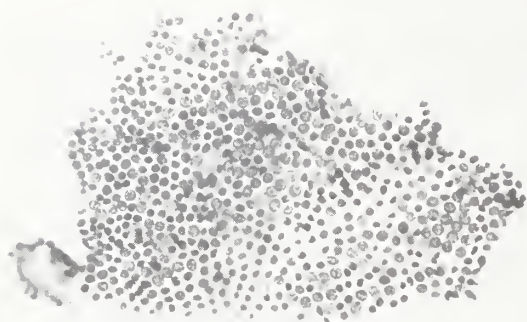


Figure 5. Benign duct epithelium. Cluster of uniform duct cells in honeycomb arrangement (Papanicolaou stain x 400).

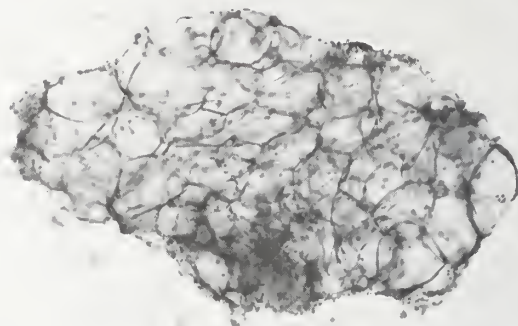


Figure 7. Adipose tissue. Each polygonal space is a fat cell (Papanicolaou stain x 100).

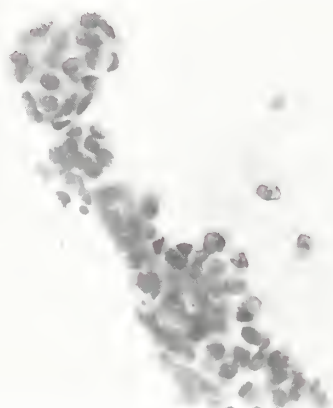


Figure 6. Papilloma. Papillary cluster of duct cells, some with crescent nucleus in a peripheral location (Papanicolaou stain x 600).

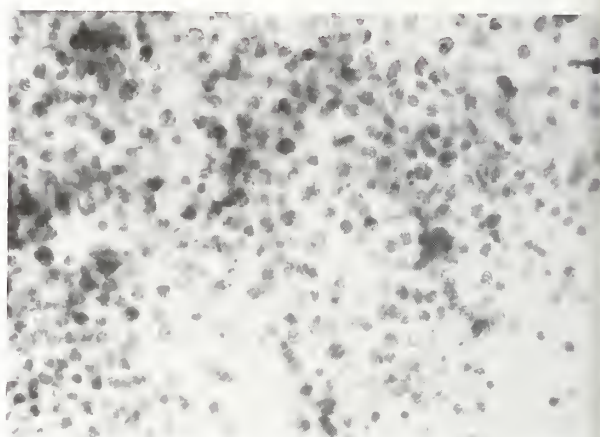


Figure 8. Carcinoma. Single and loosely cohesive malignant cells showing pleomorphism and hyperchromatism (Papanicolaou stain x 400).

0.14 to 30.4 percent and our incidence of inadequate smears falls within this range.

Literature searches reveal that clinicians may be reluctant to use aspiration cytology for the diagnosis of breast tumors due to the possibility of seeding the needle tract with malignant cells and the subsequent increased risk of distant metastases.^{2,14} Two such cases have been reported, both lung aspirations, using the large Vim-Silverman needle.⁹ Robbins and colleagues¹⁰ and Berg and Robbins¹⁶ have demonstrated that this fear is unfounded with a long-term (20 years) followup of patients with breast cancer who had needle aspiration and nonaspirated controls.

Nipple discharge smears have been included in this series. This type of exfoliative cytology is used primarily to detect a cancer not yet clinically apparent and shares many advantages with the aspiration cytology: it is painless, fast, simple, and cost effective; can be conveniently performed in the physician's office or as an outpatient procedure in the hospital; and offers no complications. Nipple discharges, even if not related directly to breast

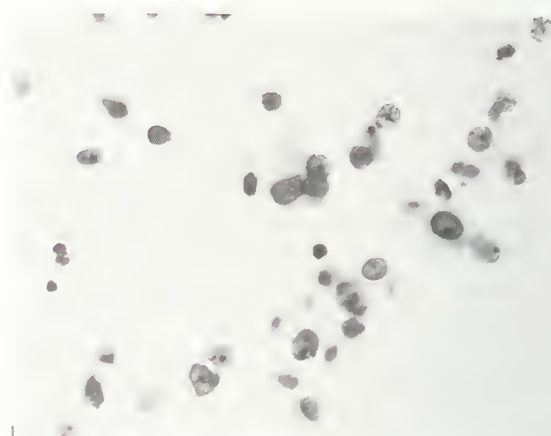


Figure 9. Carcinoma. High-power view of malignant cells with anisocytosis, anisonucleosis, irregular chromatin, and prominent nucleoli (Papanicolaou stain x 600).

cancers, may be an expression of benign disease which itself has an increased incidence of association with cancer.

Table 3 demonstrates the frequency of fine-needle aspirations of the breast and nipple discharge

years at our institution during the years under study.

Nipple discharges of the male breast are uncommon; there was only one case in this study. Nipple discharges may occur in benign disorders such as necromastia and intraductal papilloma as well as carcinoma. If the discharge is bloody, the association with malignancy is increased.^{17,18} Consequently, even though cancer of the male breast is an uncommon disease, accounting for less than 1 percent of all breast cancers, cytologic evaluation of male nipple discharges is valuable and highly recommended. The cytologic criteria to diagnose malignancy essentially are the same as for the female.

Aspiration cytology most frequently is used to evaluate breast lesions in patients who present initially with a mass. It also is useful in the evaluation of recurrent masses in patients with fibrocystic disease; in the assessment of breast lesions in patients with history of breast carcinoma because there is an increased risk of developing recurrence, metastasis, contralateral primary carcinoma; and in the study of biologic behavior of tumor cells during radiotherapy and chemotherapy from repeated aspirations.³ These latter studies are performed using cytochemical stains and tissue cultures and, additionally, fine-needle aspiration biopsy can be used to assay estrogen receptors.¹⁹ Silfriesward concluded that aspiration cytology biopsies contain enough material for receptor analysis using the method of isoelectric focusing in slabs of polyacrylamide gel.¹⁹ Thin-needle aspiration biopsy is a

procedure whose time has come²⁰ and is beginning to show its versatility.

According to Bell,⁷ clinically abnormal areas in the breasts studied by aspiration have detected 87 percent of cancers; in contrast, clinical and mammographic examination have detected 79 percent, and the combination of clinical, cytologic, and mammographic examination increases the detection figure to 93 percent of the malignant neoplasms.

Fine-needle aspiration cytology of the breast and exfoliative cytology from nipple discharges are simple, specific, and accurate procedures for the detection of breast cancer.

SUMMARY

We reviewed 216 breast cytology specimens received by the Department of Pathology, Monmouth Medical Center from 1983 to 1985. The majority of cases (131) were fine-needle aspiration biopsies and 85 cases were nipple discharge smears. The cytologic diagnoses were correlated with the histologic diagnoses in 78 cases and with the clinical impression in the remainder. This study demonstrates that cytologic diagnosis of breast lesions is a specific, accurate, and clinically useful procedure. The sensitivity, specificity, predictive value of a positive result, and predictive value of a negative result were 38.5, 100, 100, and 89 percent, respectively. The relatively low sensitivity was due to the number of false-negative diagnoses inherent in the procedure and, therefore, a negative aspiration cytology in a clinically suspicious lesion must be followed by a surgical biopsy. ■

REFERENCES

1. Martin HE, Ellis EB: Biopsy by needle puncture and aspiration. *Ann Surg* 92:169-181, 1930.
2. Zajdela A, Ghossein NA, Pilleron JP, et al.: The value of aspiration cytology in the diagnosis of breast cancer: Experience at the Foundation Curie. *Cancer* 5:499-506, 1975.
3. Zajicek J, Franzen S, Jakobsson P, et al.: Aspiration biopsy of mammary tumors in diagnosis and research, a critical review of 2,200 cases. *Acta Cytol* 11:169-175, 1967.
4. Kern WH: The diagnosis of breast cancer by fine-needle aspiration smears. *JAMA* 241:1125-1127, 1979.
5. Wilson SL, Ehrmann RL: The cytologic diagnosis of breast aspirations. *Acta Cytol* 22:470-475, 1978.
6. Somers RG, Young GP, Kaplan MJ, et al.: Fine-needle aspiration biopsy in the management of solid breast tumors. *Arch Surg* 120:673-677, 1985.
7. Bell DA, Hajdu SI, Urban JA, et al.: Role of aspiration cytology in the diagnosis and management of mammary lesions in office practice. *Cancer* 51:1182-1189, 1983.
8. Wallenberg NJ, Caya JG, Clowry LJ: Fine-needle aspiration cytology of the breast. A review of 321 cases with statistical evaluation. *Acta Cytol* 29:425-429, 1985.
9. Frable WJ: Needle aspiration of the breast. *Cancer* 3: 671-676, 1984.
10. Rosen P, Hajdu SI, Foote FW: Diagnosis of carcinoma of the breast by aspiration biopsy. *Surg Gynecol Obstet* 134:837-838, 1972.
11. Kline TS, Joshi LP, Neal HS: Fine-needle aspiration of the breast: Diagnoses and pitfalls. A review of 3,545 cases. *Cancer* 44:1458-1464, 1979.
12. Hammond S, Keyhani-Rofagha S, O'Toole RV: Statistical analysis of fine-needle aspiration cytology of the breast. A review of 678 cases plus 4,265 cases from the literature. *Acta Cytol* 31:276-280, 1987.
13. Lever JV, Trott PA, Webb AJ: Fine-needle aspiration cytology. *J Clin Pathol* 38:1-11, 1985.
14. Frable WJ: Thin-needle aspiration biopsy: A personal experience with 469 cases. *Am J Clin Pathol* 65:168-182, 1976.
15. Robbins GF, Brothers JH III, Eberhart WF, and Quan S: Is aspiration biopsy of breast cancer dangerous to the patient? *Cancer* 7:774-778, 1954.
16. Berg JW, Robbins GF: A late look at the safety of aspiration biopsy. *Cancer* 15:826-827, 1962.
17. Fujii M, Ishii Y, Wakabayashi T, et al.: Cytologic diagnosis of male breast cancer with nipple discharge. A case report. *Acta Cytol* 30:21-24, 1986.
18. Ciatto S, Bravetti P, Cariaggi P: Significance of nipple discharge, clinical patterns in the selection of cases for cytologic examination. *Acta Cytol* 30:17-20, 1986.
19. Silfriesward C, Hulma S: Estrogen receptor analysis on needle aspirates from human mammary carcinoma. *Acta Cytol* 24:54-57, 1980.
20. Koss LG: Thin-needle aspiration biopsy. *Acta Cytol* 24:1-3, 1980.

When it comes to your patients' health leave no stone unturned.



Lithotripsy at

The New Jersey Kidney Stone Treatment Center can be the alternative

Convenience—The New Jersey Kidney Stone Treatment Center is centrally located in downtown New Brunswick, near major highways, for easy access for you and your patients.

Flexible scheduling—The Center offers scheduling with no delay. In most cases, your patient can be treated within a week of your call. Our extended hours allow you to make appointments at the convenience of both you and your patients.

Bath-free equipment—The Center is equipped with the most advanced Dornier HM4 lithotripter, eliminating the need for a water bath, allowing for easier patient handling and greater patient comfort. Also in use is a state-of-the-art Shimadzu Hydrojust III cystoscopy table.

Experienced, professional staff—The staff of the New Jersey Kidney Stone Treatment Center is well-versed in lithotripsy treatment, and includes board-certified Anesthesiologists, critical-care trained nurses and skilled lithotripsy technicians.

Physician billing—Urologists treating patients at the Center have the advantage of billing their patients or third-party payers directly through their own offices.

Easy referral system—If desired, physicians can easily refer their patients to one of our staff Urologists for lithotripsy treatment.

HMO eligibility—The Center has established arrangements with most major area HMO's.

For more information regarding how the Center can help you and your kidney stone patients, call 1-800-542-8887 or (201) 937-8614.

New Jersey Kidney Stone Treatment Center

**Located at Robert Wood Johnson University Hospital
New Brunswick, New Jersey 1-800-542-8887**

The New Jersey Kidney Stone Treatment Center is operated by Health Harizans (ESWL), L.P., affiliated with the following hospitals: Community Memorial Hospital, Freehold Area Hospital, Helene Fuld Medical Center, Jersey Shore Medical Center, Raritan Bay Medical Center, Riverview Medical Center, Robert Wood Johnson University Hospital, St. Francis Medical Center, St. Peter's Medical Center, Somerset Medical Center.

Trends in Cesarean Section Rates

GEORGE J. HALPIN, MD, MPH
ELAINE ROSE, PhD
ELIZABETH SHAPIRO, MPH

Analysis of rates of primary cesarean section by level of perinatal designation and of individual hospitals with rates in excess of 20 percent show the increased utilization of cesarean sections between 1967 and 1986. Recommendations are made for reducing the utilization of cesarean sections at the hospital and physician levels.

The percentage of births occurring as a result of cesarean delivery has risen steadily in the United States from 4.5 percent of all births in 1965 to 22.7 percent of births in 1985. This percentage is among the highest in the western world.^{1,2} Over the past five years, concern about this and has been raised in both the popular press and professional journals.^{3,4} The analysis presented here is a descriptive study of primary cesarean delivery rates in New Jersey.

The standard indications for performing a cesarean section have changed little over the past decade, and include both maternal and fetal factors such as: previous uterine surgery, breech presentation, fetal distress, mechanical dystocia, and fetopelvic disproportion.^{1,5-7} Because of the underlying variation in the distribution of women at risk

for cesarean delivery, and the lack of uniform criteria for diagnosing fetal distress and fetopelvic disproportion, it is expected that there would be wide variation in cesarean section rates among hospitals and individual practitioners. Analyzing the extent of this variation would assist in developing a range of expected cesarean delivery rates, and may help develop strategies through which any excessive utilization could be identified and possibly reduced in New Jersey.

METHODS

Since 1967, New Jersey's maternity service hospitals have participated in a unique information system, based on the uniform Maternity Service Logbook, prepared by the Maternal and Child Care Committee of the Medical Society of New Jersey. Based on the data recorded for each delivery, summary information on maternal and infant complications for all deliveries is sent to Maternal and Child Health Services (MCHS).

Maternity Service Reports were submitted to MCHS on an annual basis through 1977. Since 1978,

Dr. Halpin and Rose and Ms. Shapiro are affiliated with Maternal and Child Health Services, New Jersey State Department of Health. Requests for reprints may be addressed to Dr. Halpin, NJDOH, 363 West State Street, Room 364, Trenton, NJ 08625.

Table 1. Cesarean section rates in New Jersey, 1967-1986.

Year	Percent* Primary	Percent* Repeat	Total
1967	2.93	2.44	5.37
1968	2.86	2.33	5.19
1969	3.34	2.45	5.79
1970	3.58	2.49	6.07
1971	4.02	2.81	6.83
1972	4.47	3.06	7.53
1973	5.53	3.17	8.70
1974	6.50	3.40	9.90
1975	7.89	2.22	10.11
1976	9.14	4.40	13.54
1977	10.18	4.94	15.12
1978	10.94	5.68	16.62
1979	11.52	6.62	18.14
1980	12.26	7.20	19.46
1981	12.59	7.59	20.18
1982	13.27	8.12	21.39
1983	13.48	8.48	21.96
1984	14.70	9.25	23.92
1985	15.58	9.25	24.83
1986	16.92	9.73	26.65

*Rates as a percent of all babies born.

reports have been submitted quarterly. This information was entered into a database, and quarterly statistical reports were prepared by MCHS and issued as the Maternity Service Report. The report contains a compilation of all data submitted by the cooperating hospitals, and, for individual hospitals, the number and rate of selected occurrences. The hospital-specific data are reported by code numbers, and the hospitals are grouped according to their classification as level I, II or III perinatal centers.

Participation in the reporting system, though voluntary, has been quite consistent over the period of this study. For the 17 years, from 1970 to 1986, where comparative data were available, an average of 95.7 percent of the state's births were included in the Maternity Service Reports; only in 1978 was the level of reporting (88.4 percent) outside the expected range (91.1 to 100.0 percent).

For 1967 through 1980, the data presented were taken directly from the annual Maternity Service Reports. The data since 1980 are from the Maternity Services database using Statistical Analysis Systems (SAS) software.⁸ The percentage of primary and repeat cesarean deliveries was calculated in each case as a percentage of all births in a given facility during the year. Analyses presented in this paper were performed using SAS software. Regression analyses were performed according to techniques described by Brown and Hollander.⁹

RESULTS

The primary and repeat cesarean section rates for New Jersey hospitals for 20 years, from 1967 to 1986,

are presented in Table 1. The rate of primary sections has increased from 2.93 percent in 1967 to 16.92 percent in 1986. Repeat sections have increased from 2.44 percent in 1967 to 9.73 percent in 1986.

A display of the data (Figure 1) indicates that the rate of increase in the primary section rate was greatest between 1972 and 1980. After a review of the data, regression analysis was performed to compare the rate of increase for three separate time periods: 1967 to 1972, 1973 to 1980, and 1981 to 1986. The later time period was selected since it covered the years after the designation of maternity service hospitals by level of perinatal care and the establishment of regional perinatal systems. Statistically significant, non-zero slopes existed for all three periods. The slope for the period 1967 to 1972 was +0.32 percent per year. During the period 1972 to 1980, the rate increased to +1.004 percent per year. Since 1980, the rate of increase has declined slightly to +0.764 percent per year. The differences in the slopes for these three time periods are statistically significant ($P < 0.05$). Despite the moderately low rate of increase in the primary cesarean section rate since 1980, the rate of increase since 1983 (+1.1 percent per year) suggests the start of a new period of rapid increase in this rate.

Table 2 shows the average primary cesarean section rates for all New Jersey maternity service hospitals for the years 1981 to 1986. As can be seen from the size of the standard deviation, the amount of variation between hospitals is quite sizable in any given year. The range in 1981 was 16.9 percentage points (4.2 to 21.1), while in 1986 it was 22.4 per-

Primary Cesarean Section Rates By Level New Jersey, 1980-1986

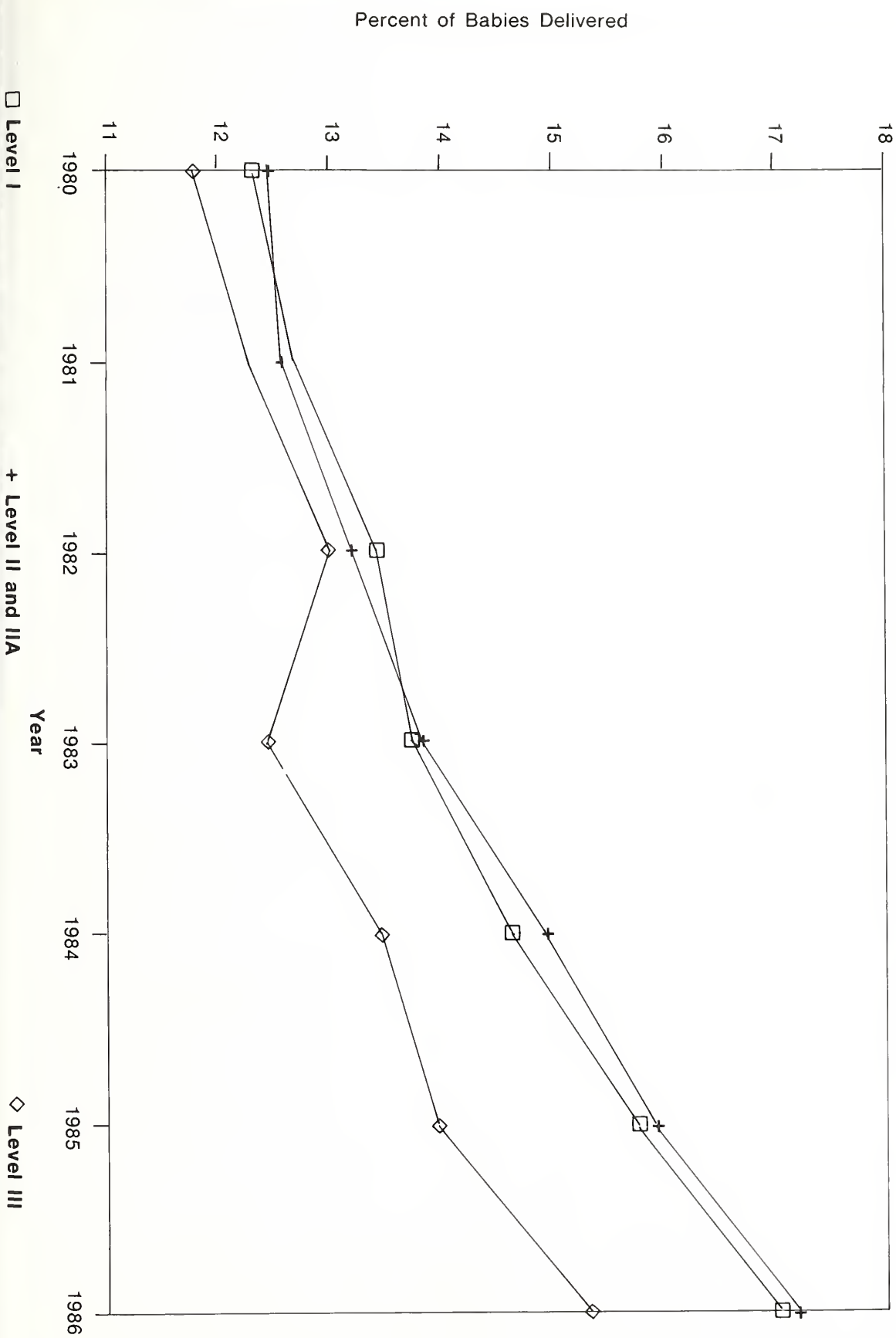


Table 2. Cesarean section rates by level, 1980-1986.

All Levels					
Year	Number of Hospitals	Average Rate	Minimum	Maximum	Standard Deviation
1980	73	12.31	4.19	21.13	3.91
1981	71	12.57	6.48	21.65	3.54
1982	71	13.27	6.35	23.96	3.88
1983	71	13.64	7.08	26.71	3.48
1984	71	14.65	5.71	25.93	5.00
1985	72	15.63	8.13	24.84	3.68
1986	71	16.94	8.67	31.11	4.09

Level I					
Year	Number of Hospitals	Average Rate	Minimum	Maximum	Standard Deviation
1980	28	12.32	4.19	21.13	4.86
1981	28	12.67	6.48	21.65	4.42
1982	28	13.42	6.35	23.96	4.86
1983	28	13.75	7.08	26.71	4.33
1984	28	14.63	5.71	25.93	5.24
1985	29	15.76	8.13	24.84	4.51
1986	28	17.06	8.67	31.11	4.92

Level II & IIa					
Year	Number of Hospitals	Average Rate	Minimum	Maximum	Standard Deviation
1980	35	12.44	6.872	19.428	3.50
1981	35	12.57	6.998	18.540	2.64
1982	35	13.21	7.091	19.475	3.32
1983	35	13.82	8.155	20.131	2.79
1984	35	14.93	9.200	22.446	3.01
1985	35	15.90	9.978	22.413	3.22
1986	35	17.21	10.669	28.008	3.71

Level III					
Year	Number of Hospitals	Average Rate	Minimum	Maximum	Standard Deviation
1980	8	11.78	7.36	19.07	3.63
1981	8	12.27	7.96	20.57	4.02
1982	8	13.00	10.55	17.29	2.34
1983	8	12.43	9.06	18.21	3.07
1984	8	13.47	9.52	17.64	2.81
1985	8	13.96	11.21	16.79	1.88
1986	8	15.33	13.06	19.14	1.95

centage points (8.7 to 31.1). In an effort to aggregate hospitals into more homogeneous groups, rates were prepared for hospitals according to their 1981 perinatal designation. The mean primary cesarean section rates for New Jersey maternity service hospitals for 1981 through 1986 by designated level of care are shown in Table 2 and Figure 2. The data show that level I and level II facilities (level II and IIa) have nearly identical average rates. Level III facilities have had lower rates for the period. The difference in rates for level III facilities became statistically significant only after 1983.

The smaller group of level III hospitals exhibited some characteristics which are notable in comparison with facilities at other levels of care. The

standard deviations for the yearly average rate for level I and level II facilities are relatively uniform and show no linear trend. In contrast, level III facilities demonstrate a narrowing of the variation within the group. This narrowing is occurring through movement of the minimum rate towards the maximum, rather than a decline in the maximum rate. Although level III facilities have a lower primary cesarean section rate after 1983, they have had the same high rate of increase in their rate as the other levels.

The distribution of primary cesarean section rates into five rate categories for the years 1981 through 1986 is shown in Table 3. The figures demonstrate that there has been a sharp decrease in the number

Cesarean Section Rates New Jersey, 1967-1986

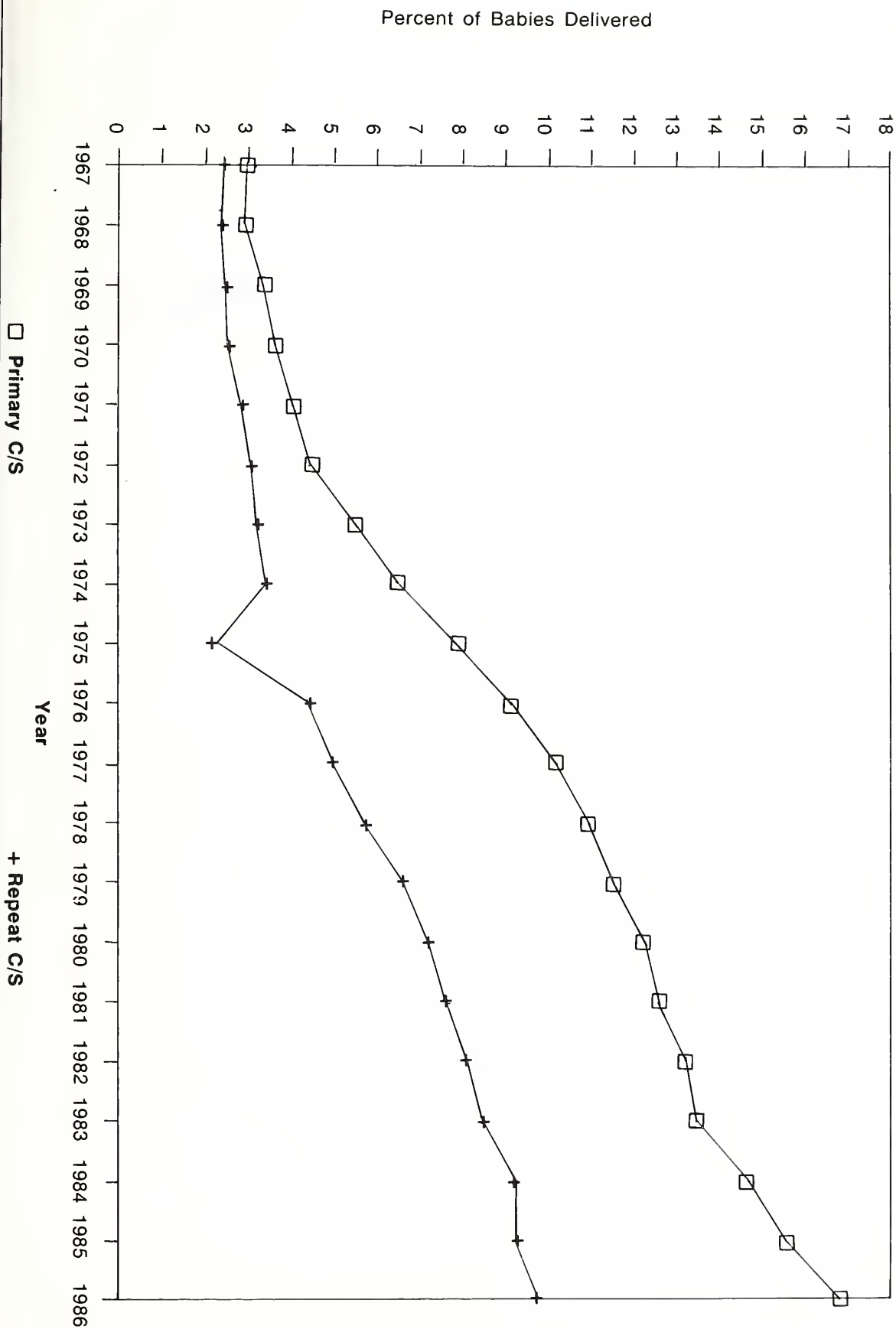


Table 3. Percent of hospitals in primary cesarean section rate groups, 1981-1986.

Year	Rate Group				
	< 10.00%	10.01%-13.00%	13.01%-17.00%	17.01%-20.00%	> 20.01%
1981	23.9%	39.4%	23.9%	7.0%	5.6%
1982	16.9%	33.8%	33.8%	11.3%	4.2%
1983	16.9%	25.4%	40.8%	12.7%	4.2%
1984	14.1%	22.5%	36.6%	18.3%	8.5%
1985	8.3%	13.9%	44.4%	23.6%	9.7%
1986	2.8%	11.3%	39.4%	25.4%	21.1%

Table 4. Distribution of hospitals by years with primary cesarean section rates over 20 percent.

Hospital	Level	Years						Total Years
		1981	1982	1983	1984	1985	1986	
A	I	X	X	X	X	X	X	6
B	I	X	X	X	X		X	5
C	I		X		X	X	X	4
D	II			X	X	X	X	4
E	I					X	X	2
F	II					X	X	2
G	II					X	X	2
H	II					X	X	2
I	I						X	1
J	I	-	-	-	-	-	X	1
K	I	X						1
L	I				X			1
M	I				X			1
N	II						X	1
O	II						X	1
P	II						X	1
Q	II						X	1
R	II						X	1
S	III	X						1

-Maternity unit not in operation.

of hospitals with primary section rates of 10 percent or less, and a corresponding increase in those hospitals with primary cesarean section rates in excess of 20 percent. In 1981, 23.9 percent of New Jersey's hospitals had a primary cesarean section rate of 10 percent or less, and 63.3 percent had rates of 13 percent or less. By 1986, those figures had declined to 2.8 and 14.1 percent, respectively.

Table 4 shows the hospitals which had primary cesarean rates in excess of 20 percent for any year since 1981. Only four hospitals (5.6 percent) in 1981 had a primary cesarean section rate in excess of 20 percent. However by 1986, that figure had increased to 15 hospitals (21.1 percent). The change in the

proportion of hospitals with rates of 20 percent or more has occurred since 1983. The greatest portion of that change took place in 1986. Of the 19 hospitals that had a primary cesarean delivery rate in excess of 20 percent in any one year since 1981, four hospitals had rates over 20 percent for at least four of the six years. Ten of the hospitals were in the group for only one year. The majority of the hospitals with a primary section rate in excess of 20 percent was classified as level II perinatal facilities.

DISCUSSION

Analysis of the maternity service data for the 20-year period, 1967 to 1986, shows that New Jersey has

experienced a fourfold increase in its total cesarean delivery rate. This increase is similar to that which has occurred for the nation as a whole. In New Jersey, the greatest proportion of the increase in cesarean deliveries came from the rise in the primary cesarean delivery rate from 2.93 percent to 16.92 percent. The smaller increase in repeat sections is not directly attributable to the occurrence of vaginal births after cesarean sections (VBACs). VBACs accounted for only 0.28 percent of all deliveries in 1981 and 0.86 percent in 1986.

Taffel proposed six explanations for the increasing utilization of cesarean delivery: 1) the continued belief in the uniform need for repeat sections; 2) increasing use of fetal monitoring; 3) the increasing tendency to deliver breech presentations by cesarean section; 4) decreased use of forceps in deliveries; 5) changing demographics of childbearing; and 6) fear of malpractice litigation.¹

Financial factors also have been considered in the rise in the rate of cesarean sections. Two studies reported that women with private insurance had the highest rates of cesarean delivery, while charity patients had the lowest.^{11,12}

The data indicate that level III perinatal centers, which manage the highest risk pregnancies, have consistently lower rates of cesarean deliveries, but their rate is increasing at a rate similar to other levels of care. All of the 15 facilities with primary section rates in excess of 20 percent in 1986 were level I or level II maternity units. The reason for this difference in rates by level of care will require further study. It is possible that the difference reflects the facility's teaching status, as indications for procedures may be more sharply defined and monitored in a teaching institution.

If an effort is to be made to reduce the number of cesarean sections, then individual obstetricians and obstetrical services will have to monitor and critically review their own performance. Quarterly rates for each maternity unit are distributed to each chief of service. It is suggested that those facilities

and physicians who have primary section rates in excess of 20 percent should review their cases and re-evaluate the indications for their decisions. It may be that their criteria for fetopelvic disproportion or fetal distress are not consistent with those of their peers, and result in an increased number of women being delivered surgically.

Because of the consistent pattern of lower primary cesarean section rates at level III perinatal centers, consultation with perinatologists at regional perinatal centers might result in the development of more uniform criteria and fewer primary cesarean sections. This regional consultation might be done on a periodic servicewide basis or on a case-by-case basis concerning the management of particular at-risk women.

SUMMARY

The national increase in utilization of cesarean section has been described by several authors. In New Jersey, the rate of primary cesarean section has increased from 2.93 percent of all infants delivered in 1967 to 16.92 percent in 1986. A growing number of hospitals in the state have primary section rates of more than 20 percent. A rise in the rate of repeat sections also has been observed.

We present data on the rising rate of cesarean sections in New Jersey maternity service hospitals. This rate increased slowly between 1967 and 1972 and rose steadily for the rest of the 1970s. The rate of increase leveled off during the early 1980s, but since 1983, a return to earlier high annual rates of increase has occurred.

Wide variation in primary section rates was observed among New Jersey hospitals. Hospitals with a level III perinatal designation had lower and more uniform rates than other facilities. Hospitals with annual rates of 20 percent or higher are specifically analyzed.

Recommendations are made for monitoring the utilization of cesarean deliveries at both the hospital and individual physician level. ■

REFERENCES

1. Taffel S, Placek P, Liss T: Trends in the United States cesarean section rate and reasons for the 1980-1985 rise. *Am J Public Health* 77:955-959, 1987.
2. Notzon F, Placek P, Taffel S: Comparisons of national cesarean section rates. *N Engl J Med* 316:386-389, 1987.
3. Weinhouse B: Cesarean sections: Why are they increasing? *Ladies Home J* 104:110, 1987.
4. Taffel S, Placek P: One-fifth of U.S. births by cesarean section. *Am J Public Health* 75:190, 1985.
5. Willson JR, Beecham CT, Carrington ER: *Obstetrics and Gynecology, 4th Edition*. St. Louis, MO, C.V. Mosby Co., 1971, pp. 463-465.
6. Queenan JT: *Management of High-Risk Pregnancy, 2nd Edition*. Oradell, NJ, Medical Economics Books, 1985, pp. 596-600.
7. Anderson G, Loman J: Determinants of the increasing cesarean birth rate. *N Engl J Med* 311:887-892, 1984.
8. SAS Institute, Inc. *SAS User's Guide*. Cary, NC, SAS Institute, 1985.
9. Brown B, Holander W: *Statistics: A Biomedical Introduction*. New York, NY, John Wiley & Sons, 1977.
10. New Jersey State Department of Health: Maternity Service Reports, 1967-1986.
11. Kizer K, Ellis A: Cesarean section rates related to payment source. *Am J Public Health* 78:96-97, 1988.
12. Placek P, Taffel S: Vaginal birth after cesarean (VBAC) in the 1980s. *Am J Public Health* 78:512-515, 1988.

The big difference between your retirement plan and AMA Advisers plan is the fees...

We have none.

Compare your present retirement plan to the "No fee" plans offered by AMA Advisers, Inc., and see the many money-saving advantages we offer.

- No charge to open or rollover to an AMA Advisers plan
- No account set-up fees
- No maintenance fees
- No charge for plan amendments to comply with changing IRS laws

Whether you have a retirement plan right now or not, mail the coupon below or call AMA

Advisers, Inc. to see how much money you'll save with us on fees and services.

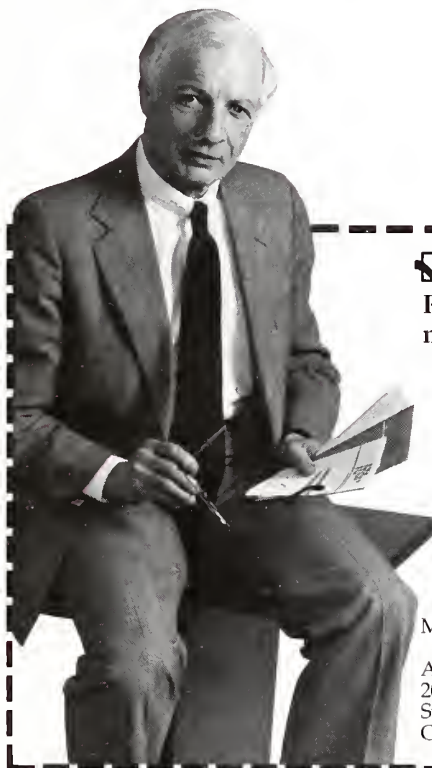
AMA Advisers, Inc., the Financial Services and Investment Counseling Organization owned by the American Medical Association, has been helping physicians and their families reach retirement goals for 23 years. And we'd like to help you.

Call toll-free today and compare. Or mail the coupon below.

1-800-523-0864

(In PA call collect
(215) 825-0400)

Serving the investment needs of
physicians and their families since 1966.



☒ **YES!** I want to know how much money the "No-fee" Retirement Plans offered by AMA Advisers, Inc. will save me. I understand I am under no obligation whatsoever.

Name _____

Address _____

City _____ State _____ Zip _____

Phone: () _____ Birth Date _____

Year In Which You Plan to Retire _____

Mail this coupon to:

AMA Advisers, Inc.
200 N. LaSalle Street
Suite 535
Chicago, IL 60664-1910

AMA ADVISERS, INC.
The Financial Services and Investment
Counseling Organization Owned by
the American Medical Association

Established in 1966



RPNFNJ

Prevention of Handgun Deaths

ROBERT EILERS, MD

Increasing numbers of deaths from firearms occurred as a consequence of the increased availability of handguns in the homes of victims. Physician counseling about the risks of handgun ownership and the implementation of stricter handgun control laws are measures needed to address this major public health problem.

The approximately 33,000 firearm-related deaths that occur annually in the United States identify guns as a major public health problem that affects individuals in every age category.¹ Guns are the second leading cause of death in the 15-to-34-age group, exceeded only by traffic accidents and well ahead of cancer deaths in third place. Firearms also are responsible for as many deaths as are automobiles in those aged 30 to 54, and are the fifth leading cause of accidental deaths of young children. There is little corresponding data on firearm morbidity, but the ratio of nonfatal gunshot injuries to fatal ones has been estimated as being one to one.² The annual cost of caring for gunshot victims in hospitals is about one billion dollars a year, although this figure does not take into account costs of rehabilitation, permanent disability and in-

come loss, or the unmeasurable costs of the pain, grief, and social and family disruption that are caused by such injuries.³

Rhetoric has obscured the fact that most deaths and injuries from firearms do not involve criminal activities, in the usual sense, but result from the use of firearms, usually handguns, in acts of suicide or from homicides committed during episodes of interpersonal and domestic violence.^{4,5} Fatalities due to these causes have been rising at an epidemic rate, particularly for women, adolescent males, and young adults.⁶ The most significant factor associated with the rise in violent death that has occurred over the last two decades has been the tremendous increase in the number of handguns in the home being used for protection and recreation.^{4,6} While conclusive data on the number of firearms are not available, estimates place this at 180 to 200 million, about a third of which are handguns.⁷

New Jersey has experienced a decline in mortalities resulting from violence over the last two dec-

Dr. Eilers is medical director, Ancora Psychiatric Hospital. Requests for reprints may be addressed to Dr. Eilers, Ancora Psychiatric Hospital, Hammonton, NJ 08037.

ades, and now has one of the lowest rates of violent death in the nation.⁸ At least partially, this phenomenon has been credited to the state's strong gun control law requiring background checks and a long waiting period prior to receipt of a permit to purchase a firearm. However, the number of suicide and homicide deaths that occurs in the state every year still is unacceptably high. Physicians, who

The most important way physicians can intervene is to interpret the health risks of firearm ownership to their patients. They must ask about firearms in the home.

should be aware of the cost of these deaths and injuries in terms of dollars and human misery, could play a much more significant role in preventing firearm-related deaths if they were to promote public policy changes and inform the public about the results of epidemiological studies that demonstrate the health risks of handguns.

PREVENTION OF FIREARM DEATHS

Violence is the leading cause of mortality in the first half of the life cycle, and ranks as the leading cause of death in terms of years of expected life lost. It can be expected to take a proportionately greater toll in the future if the current rate of violent death continues and the major diseases come under increasing control. This has occurred because the traditional law enforcement approach to dealing with violence is mainly concerned with guns in the hands of criminals; it cannot be expected to deal effectively with the vast majority of homicides committed by acquaintances and relatives, nor does it have any impact on the even greater number of suicide deaths. In order to have any real impact on this problem, it will be necessary to broaden the focus and utilize a public health perspective that emphasizes public education and preventive techniques. Such a model already has been effective in changing public attitudes and producing a reduction in behaviors leading to drunken driving, smoking, and heart disease.

The failure to address the public health aspects of handgun deaths has meant that there has been relatively little research into its causes and only minor prevention efforts. However, recently the surgeon general,⁹ American Academy of Pediatrics,¹⁰

and the American Medical Association⁷ have taken a strong position, endorsing a public health approach and calling for a campaign to promote awareness of violence and the need to reduce the widespread availability of handguns. In addition, the Centers for Disease Control has established a Violence Epidemiology Branch that has set national goals for the reduction of morbidity and mortality from suicides and homicides. Physicians should become advocates for policies that support these and other public health approaches.

The most important way physicians can intervene is to interpret the health risks of firearm ownership to their patients. They must ask about the presence and accessibility of firearms in the home, particularly if there are children, adolescents, or depressed individuals, or when there is evidence of family conflicts, including spouse or child abuse. Those who own guns must be made to realize they are not being protected from violence, but actually are more at risk of shooting themselves or an acquaintance rather than an intruder, since the vast majority of burglaries occur while no one is at home, and the shooting of someone who is breaking into a home is a very rare event.

As demonstrated in a recent study, for every act of self-protection that resulted in the death of an intruder, there were 1.3 accidental deaths, 4.6 criminal homicides, and 37 deaths by suicide.⁵ Overall, it is 18 times more likely that a gun will be used to kill someone in the home than to kill an intruder. If counseling is unsuccessful and patients will not consider the removal of a handgun from their home, they should at least be willing to prevent access to it by always storing the gun unloaded and locked away, while its ammunition is locked in a separate cabinet.

In addition to discussion of handguns, physicians must be alert to signs of interpersonal and domestic violence and be willing to take preventive measures in the overt presence of child, spouse, or elder abuse. Although physicians should always be able to provide practical assistance by appropriate referral to local schools, churches, shelters, mental health clinics, and hospitals, they also should feel comfortable if there is a need to directly counsel patients who express difficulties related to child rearing or family management. Psychiatrists, in particular, should take the lead by sharing with colleagues and patients their knowledge about the dynamics of conflict resolution and the techniques of anger and stress reduction.

GUN CONTROL

Because modifying risk behavior is difficult, the only effective way of saving lives may be to develop public policies that address the widespread avail-

availability of handguns, which are responsible for the increasing rate of violent death in our society. One way to estimate the effectiveness of gun control laws is to compare the United States with other countries that have more stringent policies. The handgun control laws of the United States are among the least restrictive of any country; it has the greatest number of handguns and a rate of homicide many times that of other countries with strong handgun laws.¹¹ However, such comparisons cannot provide conclusive evidence of the effectiveness of these laws, because of the presence of many economic, social, and cultural factors could account for varying homicide rates.

A recent study tried to overcome this problem by examining the rate of assaults and homicides in two cities which were very closely matched for a host of demographic factors.¹² Although the cities had similar crime rates, they differed in that one had a strict handgun control law that resulted in a much lower prevalence of handguns. The researchers found that, when all other factors were controlled, the city with the more stringent handgun laws and lower prevalence of handguns also had much lower rates of gun assaults and homicides.

Another series attempted to examine the effects of gun control laws on the suicide rates of regions in the United States.¹³ While findings are inconclusive, one study comparing the strictness of gun control laws with the rate of homicide and suicide in each state did give weak support to the preventive effect of handgun laws in reducing homicide rates. More importantly, there was a clear correlation between strict laws and lower firearm suicide rates. It suggested that the total suicide rate also was lower in states with strong laws, even

though there was evidence that a relatively small number of individuals intent on suicide did switch to another method because guns were not available.

New Jersey was one of the first states to pass what would become a model gun control law in the wake of the assassination of President Kennedy in 1966. This law is strict in comparison to other states because it requires a background check by police prior to approval of a license for each gun, the purchase of which may be delayed as long as 60 days. The police report that they have been able to prevent at least 10,000 convicted felons from buying handguns in the 19 years since the law went into effect.¹⁴ As a result, the firearm-related homicide rate in New Jersey is less than half the national average, although its nonfirearm homicide rate is almost equivalent to the national rate.¹⁵

Despite its strong laws, the number of guns registered in the state is 965,000.¹⁶ Although the state legislature had not approved any previous bills which were designed to strengthen its gun control laws even further, they now are considering whether to pass a law banning the possession of handguns and assault rifles by most of the general population; and this issue will be on the ballot of the upcoming election in the form of a nonbinding referendum. The proposed law would allow those who currently own guns to keep them, but upon their death their heirs would be required to sell the guns to the state. Physicians have been on both sides of the debate in the past, although there are reports that they, like the majority of the general population, have been in favor of stricter handgun controls.¹⁷⁻¹⁹ However, with the shift in the focus of this debate away from the issues of crime to that of public safety, physicians should raise their voices even more. ■

REFERENCES

1. Baker SP: Without guns, do people kill people? *Am Public Health* 75:587-588, 1985.
2. Jagger J, Dietz PE: Death and injury by firearms: Who cares? *JAMA* 255:3143-3144, 1986.
3. Martin MT, Hunt TK, Hulley SB: The cost of hospitalization for firearm injuries. *JAMA* 260:3048-3050, 1988.
4. Baker SP, O'Neil B, Karpf RS: *The Injury Fact Book*. Lexington, MA, Lexington Books, 1984.
5. Kellerman AL, Reay DT: Protection or peril: An analysis of firearm-related deaths in the home. *N Engl J Med* 314:1557-1560.
6. Wintemute GJ: Firearms as a cause of death in the United States, 1920-1982. *J Trauma* 27:532-536, 1987.
7. American Medical Association Council on Scientific Affairs: Firearms injuries and deaths: A critical public health issue. *Public Health Reports* 104:111-120, 1989.
8. Greenberg M: Death rates in New Jersey. *NJ MED* 95:950-953, 1988.
9. Department of Health and Human Services: Department of Justice Surgeon General's Workshop on Violence and Public Health Report, DHHS publication number R-D-MC 86-1. Rockville, MD, US DHHS, Public Health Service, 1986.
10. Committee on Accident and Poison Control: Policy statement: Handgun control. *AAP News*, August, 1985.
11. Goldstein JH: *Aggression and Crimes of Violence*. Oxford, England, Oxford University Press, 1986.
12. Sloan JH, Kellerman AL, Reay DT, et al.: Handgun regulations, crime, assaults and homicide: A tale of two cities. *N Engl J Med* 319:1256-1262, 1988.
13. Lester D: *Can We Prevent Suicide?* New York, NY, AMS Press, 1987.
14. Cool lobbying to protect hot heads. *The Economist* 308:30-31, 1988.
15. Baker S: Baker response (letter). *Am J Public Health* 75:1451, 1985.
16. Kerr P: Race in Jersey is showdown on gun issue. *The New York Times*, December 19, 1988: A15-B1.
17. Fennelly JF: Opinion: Do we need national gun control laws? *NJ MED* 82:63, 1985.
18. Baron RJ: Gun control law (letter). *NJ MED* 82:413, 1985.
19. Browning CH: Handguns and homicide: A public health problem. *JAMA* 236:2198-2200, 1976.

WE CAN MAKE YOUR LIFE EASIER

with practice management services by

Rosewood Medical Management

- Improve accounts receivable
- Decrease billing problems and complaints
- Always courteous to your patients when they call
- Improve diagnosis and procedure coding accuracy
- Optimize third party reimbursements
- Electronic claim submission:
 - Blue Shield of New Jersey
 - Medicare

All specialties

For further information, contact Valerie Wood



Rosewood

MEDICAL MANAGEMENT, INC.

27 MECHANIC STREET
RED BANK, NJ 07701
(201) 576-8100

Medicalstructures

DESIGNERS-ARCHITECTS-BUILDERS

**NEW JERSEY'S FOREMOST
BUILDERS OF WALK-IN
MEDICAL FACILITIES & OFFICES
COMPLETE DESIGN,
ARCHITECTURE & FINISHED
CONSTRUCTION IN A SINGLE
WORRY-FREE PACKAGE.**

FOR FURTHER INFORMATION
AND REFERENCES—PHONE
TOLL FREE

1-800-325-2160

* A DIVISION OF

J.S. HARPER CO.

2430 E. LINDEN AVE.
LINDEN, N.J. 07036

T H E V I T A L S I G N O F PHYSICIANS' INSURANCE



More NJ physicians choose MSNJ Group Health Care Plans than all other policies combined — because they know how vital quality health care insurance is.

- Blue Cross/Blue Shield and Major Medical Insurance
- Dental Insurance
- Long-Term Care Insurance

F O R M O R E I N F O R M A T I O N
CALL The Insurance Solutions People at 609 895-1616

DONALD F. SMITH & ASSOCIATES

Radiotherapy T₁ Glottic Carcinoma

ANDREW I. ZABLOW, MD
PAUL S. ERBA, MD
LOUIS J. SANFILLIPPO, MD

From 1970 to 1985, curative radiotherapy was administered to 63 patients with stage I carcinoma of the true vocal cords. Precision radiotherapeutic technique yields cure rates comparable to surgical results. Good voice quality was preserved in a high percentage of patients.

Stage I vocal cord cancer is a highly curable disease. Both surgery and radiotherapy produce five-year cure rates of 90 percent or better.¹⁻⁶ Radiotherapy has become more widely accepted in recent years because it also offers preservation of normal voice and, hence, a superior quality of life.⁷ The purpose of this report is to review a series of 63 stage I invasive glottic cancers treated with megavoltage (MV) irradiation from 1970 to 1985. Treatment techniques, local control, functional results, and long-term survival will be analyzed.

METHODS AND MATERIALS

During the 15-year period reviewed, 63 patients with carcinoma confined to the true vocal cord(s) with normal mobility were treated in the Department of Radiation Oncology at Saint Barnabas Medical Center, Livingston. These were all AJC staged T₁N₀M₀ glottic cancers. The followup time ranged from 2 to 13.8 years. The median followup was 5.5 years. Five patients irradiated for vocal cord carcinoma in situ were excluded.

The age range was 32 to 85 years, with a median

age of 64 years. Approximately 66 percent (40/63) of patients were between 60 and 85 years old. There were 56 males and 7 females. Hoarseness was the

Table 1. Disease-related variables.

Tumor Grade/ Extent	No. Patients LR/Total	%
Grade I	2/16	12.5
II	4/29	13.8
III	1/3	33.3
Unspecified	1/15	6.6
One Cord	8/59	13.5
AC/Both Cords	1/4	25

LR: Local recurrence.

AC: Anterior commissure.

presenting symptom in 61 of 63 patients. Histological diagnosis of invasive squamous cell carcinomas was established in all cases. Histological grade was specified in 48 cases: 16 cases were grade I carcinomas, 29 cases were grade II carcinomas, and 3 cases were grade III carcinomas. Disease was limited to one cord in 59 patients and involved both cords or the anterior commissure in 4 patients.

Radiation Therapy. External beam irradiation was administered with cobalt-60 teletherapy in 58 patients and with a 6 MeV linear accelerator in 5

Drs. Zablow, Erba, and Sanfillippo are affiliated with the Department of Radiation Oncology, Saint Barnabas Medical Center, Livingston. Requests for reprints may be addressed to Dr. Zablow, Department of Radiation Oncology, Saint Barnabas Medical Center, Old Short Hills Road, Livingston, NJ 07039.

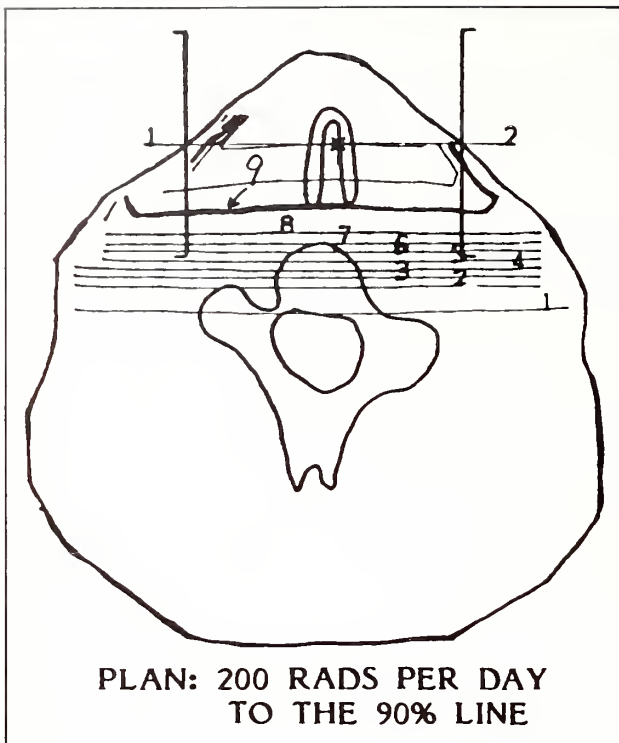


Figure 1. Cobalt-60 isodose distribution at central axis with lateral open opposed ports, SSD 75 cm, 5 x 5 cm ports. Target dose is noted by "X" symbol and represents 100 percent. The triangular-shaped treatment volume has a dose gradient of 90 to 100 percent. Note decreased doses in posterolateral neck. Spinal cord dose is less than 10 percent.

patients. Techniques employed were open opposed lateral fields in 23 cases and anterior oblique wedged ports in 40 cases. From 1970 to 1981, planning was done by x-ray simulation. Since late 1981, all patients were planned with computed tomography (CT) simulation and only the anterior oblique technique was used. For both techniques, patients were treated supine with appropriate head immobilization and cardboard cut-outs for accurate daily repositioning. Beam verification films were taken prior to treatment and then at weekly intervals.

Treatment parameters were kept uniform and determined throughout the entire period of study. Standard field sizes were 5 x 5 cm. Oblique-wedged ports were angled 60° from the patient's midline. Treatments were given five times a week. Mean daily target doses to the tumor volume were 200 cGy in 78 percent of cases, with the remainder receiving doses of up to 225 cGy. Total target doses ranged from 5,887 to 7,040 cGy, with only 5 percent exceeding the 6,600 cGy level. The treatment volume received 6,000 cGy as defined by the 90 percent isodose line in 87 percent of cases (Figures 1 and 2). Total elapsed times for treatment courses varied from 35 to 58 days and 75 percent within 42 to 49 days.

Local side effects generally were mild and consisted predominantly of temporary hoarseness (97

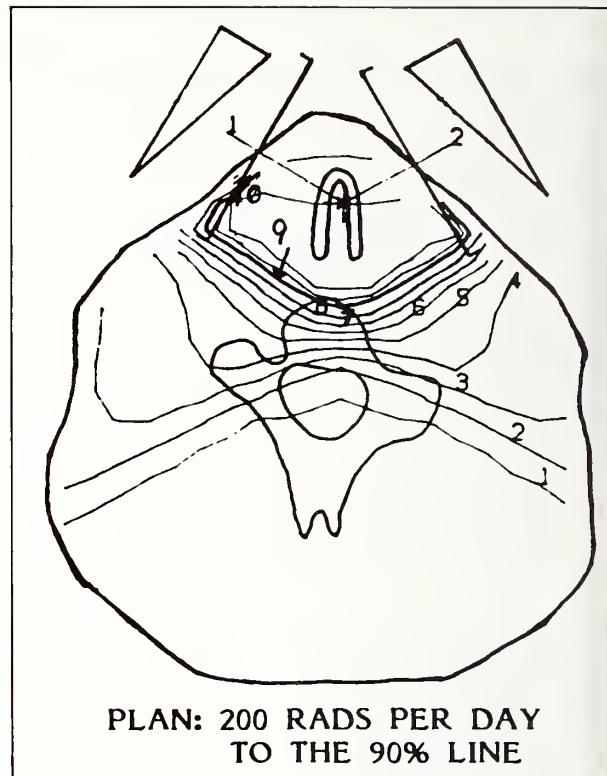


Figure 2. Cobalt-60 isodose distribution at central axis with anterior oblique wedged ports, SAD 75 cm, 5 x 5 cm ports. The diamond-shaped isodose distribution displays adequate margins around the glottis. Dose gradient in treatment volume 90 to 100 percent. The subcutaneous dose is 70 percent anteriorly, and reduced posterolaterally to 40 to 70 percent. Spinal cord dose is less than 20 percent.

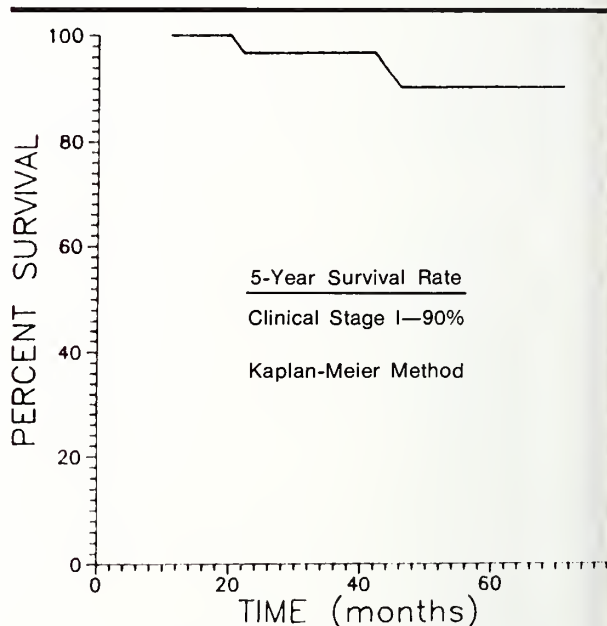


Figure 3. Kaplan-Meier actuarial survival curve.

percent). Other local side effects included transient cough and dysphagia. Patients were followed close for early detection of recurrence. All local failures were treated surgically; eight cases were treated b

Table 2. Radiotherapy for stage I CA larynx local recurrence versus technique.

Technique	No. Patients LR/Total	% LR	P Value
Lateral Opposed Ports	4/23	17.4	0.143
Anterior Oblique Wedged Ports	5/40	12.5	
X-ray Simulation 2/18		(11)	
CT Simulation 3/22		(13.6)	
			Not significant

LR: Local recurrence.

Table 3. Results of post-irradiation recurrences after salvage surgery.

Patients	Survival Results	Postsurgery
3	Alive NED	3.5, 12.5, 3.5 years
2	Dead ICD	4, 10 years
2	Dead LR	2.5, 8.3 years
2	Dead 2nd Primary	1, 2 months

NED: No evidence of disease.
ICD: Intercurrent disease. LR: Local recurrence.

Table 4. Voice quality.

	Patients	Percent
Good	34	77
Fair	10	21
Poor	3	6
Total	47	

total laryngectomy and one case was treated by laser surgery.

Results. Actuarial survival rates are shown in Figure 3 and were computed by the Kaplan-Meier method including deaths from recurrent cancer, intercurrent disease, and second primary malignancies. The five-year survival rate is 90 percent. Only 3 percent (2/63) of the cases died of uncontrolled laryngeal carcinoma (Figure 3).

Local control was achieved in 86 percent (54/63) of the cases with radiotherapy alone. In the 9 patients who developed local failure after full-course radiotherapy, local persistence of recurrence became evident from 1 to 39 months' post-treatment. More than 75 percent (7/9) of all recurrences were manifested within two years. All recurrences developed within the irradiated larynx.

Local recurrence compared to histological grade and extent of glottic involvement are seen in Table 1. Local recurrence rates were lowest in the unspecified group, almost identical in grades I and II, and highest in the small grade III group. The recurrence rate for the 4 patients with involvement for the

anterior commissure or both vocal cords almost was twice that found in the 59 patients with unilateral disease.

Local recurrence versus technique is noted in Table 2. There was no statistically significant difference between local recurrence rates found with lateral opposed ports (17.4 percent) and those treated with anterior oblique wedged ports (12.5 percent). No difference was noted in those planned with CT simulation versus conventional x-ray simulation.

Surgical treatment was performed in all cases with local recurrence (Table 3). No significant complications of surgery occurred. Surgery controlled local disease in seven of nine cases (78 percent). Of the eight cases with total laryngectomy, five patients remained free of disease from 3.5 to 12.5 years. Laser surgery was employed in one patient with advanced lung cancer. At autopsy, one month later there was no evidence of glottic disease.

Voice quality after radiotherapy treatment was assessed in 47 of the 63 cases (Table 4). Excluded were the nine patients with surgery for recurrence and seven patients with inadequate followup data for evaluation of voice function. Voice function was good (normal) in 72 percent, fair (functional) in 21 percent, and poor (persistent hoarseness) in 7 percent.

No late sequelae of cartilage or vocal cord necrosis, or chronic laryngeal edema were noted. Mild subcutaneous fibrosis was evident clinically in many patients treated with the lateral opposed port technique but was virtually absent in those treated by anterior oblique ports.

DISCUSSION

Primary radiotherapy has largely replaced surgery as the treatment of choice for T₁ glottic carcinomas because it preserves the larynx in 85 to 90 percent of patients and maintains the natural voice.¹⁻⁷ Also, radiation treatment of early lesions suitable for voice-sparing operations produces equal cure rates but provides much better voice quality.² A review of results of primary radiotherapy for T₁ tumors from 14 institutions worldwide revealed an average local

control rate of 89 percent and five-year actuarial survival rate of 96 percent.⁶

Results of our study compare favorably, achieving 86 percent local control, 78 percent surgical salvage, and five-year actuarial survival of 90 percent uncorrected from death by other causes. Good or normal voice quality after radiotherapy for T₁ or T₁-T₂ lesions has been recorded consistently in the 75 to 80 percent range.^{3,5-7} In our series, 72 percent of patients had good (normal) quality voices after successful irradiation.

Factors that determine the effectiveness of primary radiotherapy are tumor characteristics and treatment parameters.^{5,9} Biological tumor factors that impact on local control for T₁ lesions are tumor size and extent. Bulky tumors and anterior commissure or bilateral cord involvement are adverse factors.^{3,5,10} Poor histological grade also has been reported to increase the risk of local recurrence,⁵ but the number of cases reported is small. Few T₁ tumors are high grade, thereby obviating statistical comparisons.¹⁰

In our series, the incidence of local failure was higher in patients with disease extending beyond one cord and with high-grade tumors, but the total number of patients involved was too small to be statistically significant.

Results of primary radiotherapy may be more dependent on treatment parameters than on tumor characteristics.⁹ Field size, treatment volume, isodose distribution, daily fraction size, and time-dose relationship clearly have been shown to affect local control, voice quality, and late complications.^{1,5,9,11-13} Precise execution of technique is mandatory to eliminate geographic misses and injury to normal tissues. Treatment of T₁ true vocal cord carcinoma can be limited to the larynx since metastasis to the neck nodes are rare. The treatment

volume of high-dose irradiation affects local tolerance. Too large a volume can increase the severity of acute and late reactions and lead to poor voice quality.^{9,11}

In our study, port sizes were kept to 5 x 5 cm to reduce local reactions while still giving adequate tumor coverage using precise and reproducible field positions. In the mid-1970s, a change in technique from lateral opposed ports to anterior oblique wedged ports was adopted to reduce further the high-dose volume.

Comparison of the isodose distribution of the two techniques shown in Figures 1 and 2 revealed that the treatment volume (90 percent line) irradiated with oblique wedged ports corresponds well with the anatomical extent of the larynx and avoids high-dose irradiation of adjacent lateral neck structures. It gives better isodose distributions in patients with short necks by avoiding the shoulders. Also, patients with thick necks and obscured anatomical landmarks are localized easily by CT simulation and can be treated to much smaller treatment volumes. The isodose distribution also is more homogeneous for patients with posterior cord involvement compared with lateral opposed ports unless wedges are used to compensate for dose fall off posteriorly.¹²

Despite meticulous planning, local control for T₁ vocal cord cancers is limited biologically by the sigmoid dose control curve.¹ Once the plateau is reached, increasing doses do not improve local control but will increase the frequency and severity of complications and lessen the quality of the voice.

The cure rates for radiotherapy versus surgery for early vocal cord malignancies essentially are equal. We recommend radiotherapy for early vocal cord cancers because the patient will obtain a functional quality voice in addition to optimal treatment results. ■

REFERENCES

1. Fletcher GH, Lindberg RD, Hamberger A, Horiot J: Reasons for failure in squamous cell carcinoma of the larynx. *Laryngoscope* 85:987-1003, 1975.
2. Dickens WJ, Cassisi NJ, Million RR, Bova FJ: Treatment of early vocal cord carcinoma: A comparison of apples and apples. *Laryngoscope* 93:216-219, 1983.
3. Mittal B, Rao DV, Marks JE, Perez CA: The role of radiation in the management of early vocal cord carcinoma. *Int J Radiat Oncol Biol Phys* 9:997-1002, 1983.
4. Kaplan MJ, Johns ME, Clark DA, Cantrell RW: Glottic carcinoma: The roles of surgery and irradiation. *Cancer* 53:2641-2648, 1984.
5. Olszewski S, Vaeth JM, Green JP, et al.: The influence of field size, treatment modality, commissure involvement, and histology in the treatment of early vocal cord cancer with irradiation. *Int J Radiat Oncol Biol Phys* 11:1333-1337, 1985.
6. Sinha P: Radiation therapy in early carcinoma of the true cords (stage I and II). *Int J Radiat Oncol Biol Phys* 13:1635-1640, 1987.
7. Harwood AR, Rawlinson E: The quality of life of patients following treatment for laryngeal cancer. *Int J Radiat Oncol Biol Phys* 11:335-338, 1983.
8. Hintz BL, Kagan AR, Wollin M, et al.: Local control of T₁ vocal cord cancer with radiation therapy: The importance of tumor character versus treatment parameters. *Head Neck Surg* 5:204-210, 1983.
9. Overgaard J, Hansen HS, Jorgensen K: Primary radiotherapy of larynx and pharynx carcinoma—a analysis of some factors influencing local control and survival. *Int J Radiat Oncol Biol Phys* 12:515-521, 1988.
10. Hjelm-Hansen M, Jorgensen K, Andersen AP, Lur C: Laryngeal carcinoma II. Analysis of treatment results using the Ellis model. *Acta Radiol* 18:385-407, 1979.
11. Schwaibold F, Scariato A, Nunno M, et al.: The effect of fraction size on control of early glottic cancer. *Int J Radiat Oncol Biol Phys* 14:451-454, 1988.
12. Thames H, Withers HR, Peters L, Fletcher C: Changes in early and late radiation responses with altered dose fractionation: Implications for dose-survival relationship. *Int J Radiat Oncol Biol Phys* 8:219-226, 1988.

Endoscopic Nasal Surgery

TONG H. CHUN, MD
TODD A. MORROW, MD

The purpose of functional endoscopic sinus surgery is to re-establish ventilation and mucociliary clearance by endoscopic removal of diseased tissue from key areas of the nasal cavity. Systematic nasal endoscopy and high resolution computed tomography provide diagnostic information that can allow for the recognition of pathology not identifiable by other means.

The key to functional endoscopic sinus surgery is an understanding of the underlying pathophysiology of sinus disease and the ability to accurately diagnose these entities. Most infections of the paranasal sinuses are rhinogenic, spreading from the nose into the sinuses. The common focus of infection often is the stenotic areas of the anterior ethmoid, especially its infundibulum, with infection recurring in the larger sinuses. Systematic nasal endoscopy, coupled with high resolution computed tomography (CT) imaging, provides complementary diagnostic information that can reveal lesions not identifiable by other means. The ultimate goal is to re-establish ventilation and

mucociliary clearance of the sinuses with minimal trauma. This endoscopic sinus surgery usually can be performed on an outpatient basis utilizing local anesthesia.

HISTORICAL PERSPECTIVES

Although the first documented attempts at nasal and sinus endoscopy were performed by Hirschmann in 1901 using a modified cystoscope, it was not until 1978 that the first systematic and detailed work documenting endoscopic findings was published in English by Messerklinger.¹ He studied mucociliary clearance of the sinuses utilizing endoscopy and noted that, wherever two mucosal layers came into contact, localized disruption of mucociliary clearance occurred, causing retention of secretions in the area of contact, thereby creating an increased potential for infection even with a patent ostium. Anatomically, areas of mucosal contact are most likely to occur in the narrow mucosal-lined channels of the middle meatus and ethmoid air cell systems.

Dr. Chun is affiliated with the Department of Otolaryngology, VA Medical Center, East Orange. Dr. Morrow is a resident, Otolaryngology/Head and Neck Surgery, MDNJ-New Jersey Medical School, Newark. Requests for reprints may be addressed to Dr. Morrow, UMDNJ-New Jersey Medical School, 185 South Orange Avenue, Newark, NJ 07103-2757.



Figure 1. CT scan with contrast, coronal view, demonstrating obstruction of the infundibula bilaterally. This results in blockage of the sinus outflow tracts with small amounts of fluid persisting on the sinus floor and evidence of mucoperiosteal hypertrophy. A large pneumatized middle turbinate is seen on the left.

Messerklinger's work on patients with chronic and recurring sinus infections helped to focus on ventilatory defects in the middle meatus and anterior ethmoids.² These areas of persistent mucosal contact occurred either as a result of mucosal inflammation and hyperplasia following an infection, or as a result of an anatomic malformation. Such interruption of normal mucociliary clearance caused both persistence of localized inflammation and affected the drainage of the frontal and maxillary sinuses, leading to the potential for recurrent infection.

In the frontal sinus, Messerklinger identified retrograde mucociliary flow from the frontal recess of the ethmoid, providing a further potential route for the introduction of infection.² As a result, Messerklinger concluded that infection spreads from the ethmoids to secondarily affect the maxillary and frontal sinuses. This idea, however, was not new. In 1966, Proctor wrote, "The ethmoid sinuses usually are the key to any problem involving infectious sinusitis. Infection generally begins there and persistent infection there usually is the reason for failure of therapy directed at any of the other paranasal sinuses."³

Other evidence also supports the concept of the anterior and middle ethmoid region as a primary site in inflammatory sinus disease. The area of the anterior end of the middle turbinate and meatus bears the brunt of inspiratory airflow. In this region, inspired air moving at a high velocity, after passing through the constricted area of the nasal valve, has to change direction of flow,⁴ and particulate impac-

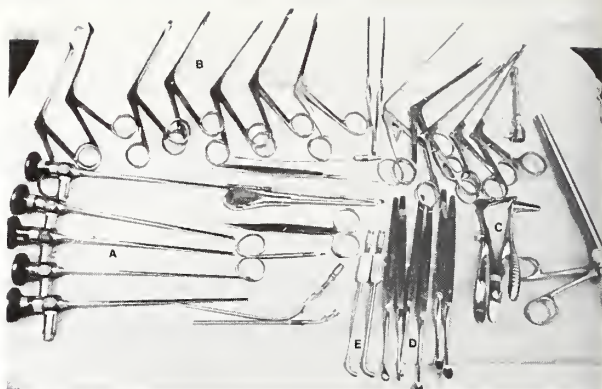


Figure 2. Endoscopic sinus surgery instruments: (A) endoscopes of various angles of view; (B) assorted straight and angled forceps; (C) nasal specula; (D) assorted curettes; and (E) curved suction tips.

tion occurs. This area is the primary site for deposition of bacterial and allergenic particles filtered by the nose, and, thereby, is important as a primary site in inflammatory diseases of the nose and paranasal sinuses. Surgical experience demonstrates that during ethmoidectomy for inflammatory disease, the anterior cells most frequently are involved, whereas the posterior cells often are relatively normal.

THE OSTEO-MEATAL COMPLEX

The importance of the middle meatus-anterior ethmoid region in the pathogenesis of frontal and maxillary sinus disease led Naumann to coin the term osteo-meatal complex (OMC) to describe this anatomic location. It has been noted that even severe mucosal disease in the maxillary and frontal sinus, which in the past often has been considered irreversible, usually undergoes resolution when normal ventilation and mucociliary clearance is restored and ethmoid disease is eradicated.⁵

The keystone of functional endoscopic sinus surgery is the ability to accurately diagnose even relatively minor changes in the osteo-meatal complex that interfere with mucociliary clearance of the frontal and maxillary sinuses. The area of the anterior ethmoid is poorly visualized on routine sinus film where only gross opacification usually is evident. Likewise, anterior rhinoscopy reveals little information with respect to the middle meatus and provides information regarding the infundibular opening and the maxillary sinus orifice. Nasal endoscopy provides the ability to accurately evaluate this area for evidence of localized disease or for anatomic defects that compromise ventilation and mucociliary clearance. Computed tomography (CT) is used to identify mucosal changes deeper in the OMC that are not visible endoscopically and to identify the extent of disease. Consequently, the diagnostic evaluation for functional endoscopic sinus surgery consists of a combined modality of systematic nasal endoscopy

nd CT, both being complementary to each other in the assessment of the OMC (Figure 1).

TECHNIQUE

The principle of the technique is limited resection of inflammatory or anatomic defects that interfere with normal mucociliary clearance and result in localized persistent inflammation (Figure 2). Since the technique involves limited surgical resection rather than wide exenteration, both an accurate diagnosis and an understanding of the pathogenesis of sinus disease are essential to a successful outcome. This approach has been used successfully in chronic and recurrent acute sinusitis, drainage of frontal sinus mucocles and of periorbital abscesses, fungal sinus disease, and as an alternative to frontal sinusotomy.

The use of endoscopes is technically demanding. In addition to intense illumination and increased depth of field, the deflected angles of view enable the removal of disease from recesses that could not be seen previously with the intranasal approach.

The maxillary sinus ostia may be visualized in the lateral wall of the middle meatus with a 30° or 70° telescope. If there is significant disease, a back-biting forceps is used to enlarge the maxillary sinus ostia anteriorly and inferiorly. The laser adds a new dimension to endoscopic surgery; it provides precision with excellent hemostasis and minimal edema. Under local anesthesia, bleeding is minimal with an average loss of 50 ml. At the termination of the procedure, antibiotic ointment is applied intranasally. A small drip pad is taped into place over the base of the nose to collect any postoperative secretions. Nasal packing usually is not required. Surgery can be performed on an outpatient basis using local anesthesia.

The indication for the endoscopic operation is obtained from the history, the endoscopic findings of the lateral nasal wall, and the results of the radiographic evaluation of the sinuses.

CLINICAL FEATURES

Classic symptoms of chronic recurring sinusitis include nasal obstruction, polyposis, postnasal discharge, and purulent rhinorrhea. With secondary symptoms (such as mucocles and mycoses), one must also recognize the symptoms that would most likely be overlooked with respect to diseased ethmoid air cells, primarily because the general

sinus x-ray film is normal in many of these cases. Often times cases of epiphora, anosmia, and neuralgias allegedly are linked to other causes, i.e. a deviated septum.

Computed tomography or polytomography of the sinuses aid in precisely localizing the ethmoid disease, make a direct bilateral comparison, and detect changes in the ethmoid area that are not visible in the general roentgenogram. This is very important; as localized mucous membrane diseases often remain invisible to rhinoscopic and even endoscopic methods.

It has been noted that even an extensively damaged maxillary mucous membrane has a great capacity to regenerate itself. The frontal and maxillary sinuses usually heal completely within two to four weeks following endoscopic ethmoidal surgery without actually having been touched. The endoscopic method of ethmoidal surgery involving infundibulotomy permits the recreation of the natural drainage and ventilatory conditions, with little strain on the patient. This is not to say there is no place for the more traditional Caldwell-Luc operations for inflammatory disease of the sinuses, but in view of our current endoscopic facilities available to us, it no longer is considered the standard state-of-the-art procedure for chronic or polypoid sinusitis.

The advantages of the functional endoscopic technique include improved diagnostic accuracy and visualization during surgery, and the ability to minimize trauma to normal structures. Conservative removal of disease is a hallmark of this technique. Because there is a wide normal variation in nasal/sinus anatomy, considerable experience is necessary both for accurate endoscopic diagnosis and for effective safe surgical intervention. The use of endoscopy and CT in the diagnosis of sinus disease has enhanced our clinical armamentarium.

SUMMARY

Functional endoscopic sinus surgery is bringing about revolutionary changes in sinus surgery, much like tympanoplasty did to radical ear surgery several years ago. It permits the clinician to diagnose pathologic changes in the paranasal sinuses earlier, and to localize them more precisely. Based on the understanding of the ethmoid's dominant role in the pathophysiology, the objective is minimal endoscopic surgery to maximize the results. ■

REFERENCES

1. Kennedy D, Zinreich SJ, Rosenbaum A, Johns M: Functional endoscopic sinus surgery. *Arch Otolaryngol* 111:576-582, 1985.
2. Messerklinger W: On the drainage of the normal frontal sinus of man. *Acta Otolaryngol* 63:176-181, 1967.
3. Proctor DF: The nose, paranasal sinuses, and pharynx, in Walters W (ed), *Lewis-Walters Practice of Surgery, Volume 4*. New York, NY, 1966, pp. 1-37.
4. Proctor D: Airborne disease and the upper respiratory tract. *Bacteriol Rev* 30:498-513, 1966.
5. Sogg AJ: Intranasal antrostomy: Causes of failure. *Laryngoscope* 92:1038-1041, 1982.



Pollution can kill.

What astronauts saw of Earth from space was a breathtaking display of natural beauty. Our world from eye level is also breathtaking — for different reasons. *ACID RAIN, BURNING AND POISONOUS LEAKING LANDFILLS, DUMPING OF RAW SEWAGE IN STREAMS, RIVERS AND OCEANS* are some of the more obvious contributions to the decline of our ecology.

Individual acts of thoughtless pollution have an accumulative effect that comes back

to haunt us all.

How about you and your family? Do you properly discard your used motor oil, old tires, beverage containers and other household trash or do you dump it in public streets, sewers and isolated spots for others to dispose.

Our World is not a bottomless pit. If we continue to abuse it, it will become uninhabitable.



**The Medical Society
of New Jersey**

2 PRINCESS RD., LAWRENCEVILLE, N.J. 08648

Acromegaly

as the Amenorrhea-Galactorrhea Syndrome

MICHAEL H. GOLDMAN, MD
KARL KLINGES, MD

The presence of amenorrhea with galactorrhea, elevated prolactin levels, and a pituitary tumor does not always imply the diagnosis of a prolactinoma. Other pituitary disorders, including acromegaly, should be considered.

The amenorrhea-galactorrhea syndrome (AGS) with increased prolactin levels (PRL) is assumed to be caused by a prolactinoma. Other diagnoses, such as nonfunctionary pituitary tumors¹ or hypothyroidism,² may simulate this presentation. The occurrence of these features as initial findings in a patient with acromegaly is distinctly unusual. The authors report a case.

CASE REPORT

A 39-year-old white female presented herself because of secondary amenorrhea of one year's dur-

Dr. Goldman is affiliated with the Department of Medicine and Dr. Klinges is affiliated with the Department of Obstetrics and Gynecology, Englewood Hospital. Correspondence may be addressed to Dr. Goldman, 600 Palisade Avenue, Englewood Cliffs, NJ 07632.

ation. During this time, she noted diminished libido and intermittent galactorrhea.

Subsequent history revealed complaints of swollen hands and skin thickening. She also noted a slight increase in her shoe size. The patient thought her problems were due to fluid retention and did not feel excessively disturbed by their occurrence.

Initially, laboratory data revealed a prolactin of 80 ng/mL (normal less than 25 ng/mL) and a follicle stimulating hormone (FSH) of 4 MIU/mL (normal premenopausal less than 25 MIU/mL). A magnetic resonance image of the pituitary showed a macroadenoma with suprasellar and slight lateral extension.

Physical examination revealed a well-developed woman with normal blood pressure and pulse. Thyroid and pelvic examinations were normal. Ga-

lactorrhea was expressible bilaterally. Skin texture was coarse; her hands were mildly and diffusely thickened. Dermal skin pores were exaggerated. Minimally coarsened hair was noted. Laboratory data revealed a normal T_3 resin uptake, thyroxine, and thyroid-stimulating hormone. Prolactins were 80 and 50 ng/mL. Growth hormone baseline and stimulated following 100 gm of glucose was increased to 30 ng/mL and 27 ng/mL, respectively (normal less than 10 ng/mL and 2 ng/mL, respectively). Somatomedin C was 3.70 U/mL (normal less than 2.2 U/mL). Cortisols, baseline and stimulated, following adrenocorticotrophic hormone (ACTH) were normal. Visual fields revealed a slight field cut to the left superior temporal area.

The patient subsequently underwent an uncomplicated transphenoidal operation with removal of a pituitary adenoma. Immunohistochemical studies of the tumor showed a predominance of growth

megaly may present a similar constellation of abnormalities although its presentation usually is overshadowed by the effects of elevated growth hormone (GH). Soft tissue overgrowth and acral enlargement are the more common manifestations of GH excess, and it is these symptoms which normally bring a patient to a doctor's attention.

The patient initially presented for medical evaluation because of amenorrhea. The findings of an elevated prolactin level, along with a pituitary tumor, suggested the diagnosis of a prolactinoma. Subsequently, additional history revealed subtle complaints of hand swelling and increasing shoe size. The finding of an elevated and nonsuppressible growth hormone revealed the correct diagnosis: acromegaly.

The amenorrhea found in acromegaly may be secondary to pituitary suppression of gonadotropins because of local tumor effects or to thyroid and/or adrenal dysfunction seen in this disorder. Additionally, hyperprolactinemia, caused by concurrent cellular production of both GH and PRL, by pituitary stalk compression with subsequent PRL disinhibition or by intrinsic prolactin-like activity from GH itself also could produce amenorrhea and the simultaneous galactorrhea.³

When the primary complaints in acromegaly are reproductive in nature, the correct diagnosis may be obscured. The similarities in presentation of a prolactinoma with this patient's complaints could be confusing and lead to a wrong diagnosis and treatment. Although bromocriptin, a dopamine agonist, is therapeutic and the treatment of choice in prolactinomas, its efficacy is limited in acromegaly. In this particular case, bromocriptin could have been partially successful in reducing prolactin levels and to a lesser degree, the growth hormone levels and thereby, could have reversed the presenting complaints of amenorrhea and galactorrhea. However, it could have masked the correct diagnosis and delayed corrective transphenoidal surgery.

SUMMARY

Not all patients with the amenorrhea-galactorrhea syndrome with elevated PRL have prolactinomas. Additional diagnoses must be considered. Other pituitary tumors and endocrine abnormalities may cause this picture. Acromegaly should be added to this list. ■

Acromegaly. A disorder marked by progressive enlargement of the head and face, hands and feet, and thorax, due to excessive secretion of growth hormone by the anterior lobe of the pituitary gland.*

*Stedman's Medical Dictionary, 24th Edition.

hormone staining cells. A few additional PRL staining cells were observed. Postoperative growth hormone diminished to 10 ng/mL and PRL normalized to 2.7 ng/mL. A course of radiotherapy was planned.

DISCUSSION

The appearance of amenorrhea, galactorrhea, and elevated prolactin levels in a patient found to have a pituitary tumor strongly suggests the possibility of prolactinoma. However, alternative diagnoses must be considered. Hypothyroidism may cause this clinical picture and may be reversed solely with thyroid hormone replacement.² Similarly, acro-

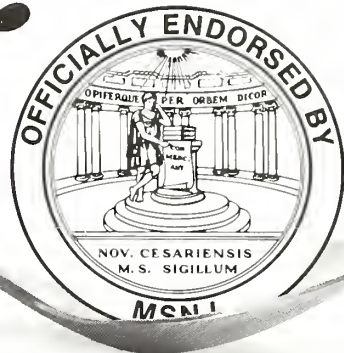
REFERENCES

1. Boulanger CM, Mashchak CA, Chang RJ: Lack of tumor reduction in hyperprolactinemic women with extrasellar macroadenomas treated with bromocriptine. *Fertil Steril* 4: 532-535, 1985.
2. Grubb MR, Ghakeres D, Malarky HB: Patients with primary hypothyroidism presenting as prolactinomas. *Am*

J Med 83: 765-769, 1987.

3. Nicoll CS, Mayer GL, Russell SM: Structural features of prolactins and growth hormones that can be related to their biological properties: *Endocr Rev* 7: 169-302, 1986.

Your own medicine.



The Exchange is the *only* company providing professional liability insurance that is endorsed and sponsored by the Medical Society of New Jersey.

The Exchange was founded in 1976 by the Society itself because New Jersey physicians urgently needed a secure, stable professional liability program. The commercial carriers had abandoned the State. The Exchange is governed by its insured physicians because a doctor-owned company can best take care of medical professionals' needs.

That's why the Exchange's membership includes more than 7,500 practicing physicians and surgeons in New Jersey... a taste of their own medicine.



**Medical Inter-Insurance
Exchange of New Jersey**

2 PRINCESS ROAD, LAWRENCEVILLE, NEW JERSEY 08648
800-257-6288 509-896-2404

WHOM TO CALL AT MSNJ HEADQUARTERS

Executive Director: Vincent A. Maressa

Address changes	Joyce Guest	Long-Range Planning	
Advertising	Joseph Cookson	Committee	Vincent A. Maressa
AIDS Task Force	A. Ronald Rouse	Loss Prevention, Risk	
AMA Delegation	Diana C. Gore	Management	A. Ronald Rouse
Annual Meeting	Eileen Pfeiffer	Maternal and Newborn Record	
Auxiliary, MSNJ	Margaret Franskiewich	Books	Joyce Guest
Biomedical Ethics	June O'Hare	Medical Assistants	Joseph C. Lucci
Blue Cross/Blue Shield	Joseph C. Lucci	Medical Education	Martin E. Johnson
Board of Trustees	Diana C. Gore	Medical Services	Joseph C. Lucci
CME	Marge Bolling	Medical Student Loan	
Council and Committee		Fund	Patricia Drakeford
Appointments	Diana C. Gore	Medicare/Medicaid	Joseph C. Lucci
Credentials	Mary Hamer	Membership Benefits	Joseph C. Lucci
Delegates, MSNJ	Eileen M. Pfeiffer	Membership Directory	Joyce Guest
DRG	Vincent A. Maressa		Arthur White
Dues Payments: MSNJ and		Membership Records	Mary Hamer
AMA	Mary Hamer	Mental Health	Joseph C. Lucci
Eye Health Screening		NEW JERSEY MEDICINE .	Geraldine Hutner
Program	Sue Arnone	Nominating Committee	Diana C. Gore
Executive Committee	Diana C. Gore	Officers of MSNJ	Diana C. Gore
Financial Operations	Arthur White	PRO	Vincent A. Maressa
HMOs/IPAs/PPOs	Joseph C. Lucci	Professional Liability	
Hospital Medical Staff		Insurance	A. Ronald Rouse
Relations	Diana C. Gore	Public Health	Joseph C. Lucci
House of Delegates	Diana C. Gore	Public Relations	Martin E. Johnson
Physicians' Health		Resident Association	A. Ronald Rouse
Program	David I. Canavan, M.D.	Resolutions for Annual	
	Linda A. Pleva	Meeting	Diana C. Gore
	Edward G. Reading	Senior Citizen Projects	A. Ronald Rouse
JEMPAC	June O'Hare	Special Projects	A. Ronald Rouse
Judicial Council	June O'Hare	Specialty Societies	Sue Arnone
Legal Services Plan	Joseph C. Lucci	Student Association	A. Ronald Rouse
Legal Questions	Vincent A. Maressa	Subscriptions	Robin L. Kennett
Legislation	June O'Hare	Third-Party Payor	
Liaison Representatives to Other		Complaints	Joseph C. Lucci
Organizations	Diana C. Gore	Widows and Orphans Program .	Joyce Guest
		Women in Medicine	A. Ronald Rouse
		Young Physicians	A. Ronald Rouse

MSNJ-609-896-1766

COMMITTEES & COUNCILS

ADMINISTRATIVE COUNCILS

Council on Legislation

(June O'Hare, Staff Liaison)

Irving P. Ratner, MD, *Chairman* Willingboro
Anthony P. Caggiano, Jr, MD,

Vice-Chairman Glen Ridge
Bartholomew R. D'Ascoli, MD,

Vice-Chairman Sparta
L. Willis Allen, MD Millville

Churchill L. Blakey, MD Wenonah

Edward D. Buch, MD Bridgewater

John P. Capelli, MD Haddonfield

Harry M. Carnes, MD Audubon

William J. D'Elia, MD Spring Lake

Anthony J. DiCroce, MD Point Pleasant Beach

William V. Harrer, MD Camden

George J. Hill, MD West Orange

John J. Hosay, Jr, MD Jersey City

David I. Kingsley, MD Edison

Howard H. Lehr, MD Gillette

David M. MacPeck, MD Lakewood

S. Stuart Mally, MD Atlantic City

James F. Marley, MD Dumont

Evangelos Megariotis, MD Clifton

Jerome A. Molitor, MD Elizabeth

Bernard A. Rineberg, MD New Brunswick

Jay S. Rosen, MD Hackensack

Edward A. Schauer, MD Farmingdale

Gabriel F. Sciallis, MD Mercerville

Irving Weiss, MD Pompton Plains

Grace Holdcraft, *Auxiliary Member* Woodbury

William D. Salerno, MD,

Resident Member Saddle Brook

Kevin J. Kerlin, MD, *Alternate Resident*

Member Voorhees

Daniel R. Alexander, *Student Member* Clark

Anthony Ingenito, *Alternate Student*

Member Wayne

Frank Gingerelli, MD, *Consultant* Hackensack

R. Gregory Sachs, MD, *Consultant* Summit

Council on Medical Services

(Joseph C. Lucci, Staff Liaison)

Richard H. Sharrett, MD,

Chairman North Plainfield

Robert S. Rigolosi, MD, *Vice-Chairman* Paramus

Alfred A. Alessi, MD Oradell

Churchill L. Blakey, MD Wenonah

Victor H. Boogdanian, MD New Brunswick

Marvin T. Boyd, MD Paterson

Joel S. Cherashore, MD Nutley

Charles L. Cuniff, MD Newark

Ames L. Filippone, Jr, MD Morristown

Joseph W. Fleisher, MD Scotch Plains

Albert Minzter, MD Roselle Park

Emmons G. Paine, MD Voorhees Township

John J. Pastore, MD Vineland

Lindsay L. Pratt, MD Vineland

Mark M. Singer, MD Englewood

Joseph W. Sokolowski, Jr, MD Cherry Hill

Matthew J. Speesler, MD Somerset

Robert H. Stackpole, MD Roselle

Narasimhaloo Venugopal, MD Vineland

B. Ralph Wayman, Jr, MD Yardley, PA

Barry R. Zitomer, MD Morristown

Joseph J. Doerr, MD, *Resident Member* Paterson

Robin Garczynski, *Student Member* Marlton

Douglas M. Costabile, MD,

Ex-Officio Member Murray Hill

Council on Mental Health

(Joseph C. Lucci, Staff Liaison)

Thomas R. Houseknecht, MD,

Chairman Moorestown

William R. Nadel, MD, *Vice-Chairman* Plainfield

Savji L. Bhatiya, MD Wall

Robert Berkowitz, MD Toms River

Harry H. Brunt, Jr, MD Beach Haven

Morton Friedman, MD Millburn

Terry A. Johnston, MD Margate

Elmar G. Lutz, MD Wayne

Rita R. Newman, MD Short Hills

James P. O'Neill, MD Avon-by-the-Sea

Douglas H. Robinson, MD Pennington

Gerald H. Rozan, MD Wayne

Kenneth J. Rubin, MD Long Branch

Nicholas F. Videtti, MD Ridgewood

Martin H. Weinberg, MD West Trenton

Michael V. Will, MD West Trenton

Angie Campo, *Auxiliary Member* Lawrenceville

Donald Ganim, II, *Student Member* Piscataway

James C. Krieg,

Alternate Student Member Summit

Palma E. Formica, MD,

Ex-Officio Member Old Bridge

Council on Public Health

(Joseph C. Lucci, Staff Liaison)

Charles J. Moloney, MD, *Chairman* Moorestown

Glenn P. Lambert, MD, *Vice-Chairman* .. Flemington
 Ronald Altman, MD Trenton
 David J. Blackman, MD Wayne
 Mary F. Campagnolo, MD Westampton
 Thomas E. Desmond, MD Edison
 Lawrence D. Frenkel, MD New Brunswick
 Eleanor A. Gonnella, MD Bloomfield
 Maceo M. Howard, MD Jersey City
 Roland E. Johnson, MD Newton
 Stanley R. Lane, MD Moorestown
 Richard R. Lorber, MD Kenilworth
 Gerald S. Packman, MD Vineland
 Rosi Rivas, *Auxiliary Member* Yardley, PA
 Vincent M.B. Silenzio,
Student Member Plainsboro
 Joseph A. Riggs, MD,
Ex-Officio Member Haddonfield

Council on Public Relations

(Martin E. Johnson, Staff Liaison)

Joseph N. Micale, MD, *Chairman* North Bergen

Ralph Cavalier, MD, *Vice-Chairman* Northfield
 Leticia V. DeCastro, MD, *Vice-Chairman* Edison
 Charles H. Arnoldi, Jr, MD South Orange
 Christopher Babigian, MD Paramus
 Harry H. Brunt, Jr, MD Beach Haven
 Leonard J. Corwin, MD Millburn
 Richard A. D'Amico, MD Englewood
 G. Jerry Falcone, MD Jersey City
 John S. Garra, MD Collingswood
 Michael M. Heeg, MD Trenton
 Charles M. Moss, MD Emerson
 Kelly M. Reid, MD Pomona
 R. Gregory Sachs, MD Summit
 Blackwell Sawyer, Jr, MD Point Pleasant
 Edith T. Shapiro, MD Englewood
 Chris Kline, *Auxiliary Member* Plainfield
 Mary E.A. Hutchins, *Student Member* Somerville
 Frank J. Malta, MD, *Consultant* Toms River
 Edwin W. Messey, MD, *Consultant* Willingboro
 William E. Ryan, MD,
Ex-Officio Member Pennington

STANDING COMMITTEES

Committee on Annual Meeting

(Eileen Pfeiffer, Staff Liaison)

Donald J. Holtzman, MD, *Chairman* Elizabeth
 Angelo S. Agro, MD Haddonfield
 Thomas K. Bills, MD Lawrenceville
 Thomas J. Connolly, Jr, MD Jersey City
 H. Irving Dunn, MD Mantoloking
 Andrew G. Hudacek, MD Morristown
 O. Andrei Kachala, MD Perth Amboy
 Satwant G. Keswani, MD Livingston
 John P. Mudry, MD Ridgewood
 Frank R. Romano, Sr, MD Dunellen
 Paul H. Steel, MD Atlantic City
 Angie Campo, *Auxiliary Member* Lawrenceville
 Bernard Robins, MD, *Ex-Officio Member* Union

Committee on Credentials

(Arthur White, Staff Liaison)

Bernard Robins, MD, *Chairman* Union
 Thomas E. Mattingly, Jr, MD,
Vice-Chairman Mount Holly
 William A. Allgair, MD South River
 Roger C. Laauwe, MD Wayne
 Thomas Logio, MD Summit
 Lawrence B. Owen, MD Salem
 Philip A. Rispoli, MD Belleville

Committee on Finance and Budget

(Arthur White, Staff Liaison)

Matis A. Fermaglich, MD, *Chairman* Teaneck
 Angelo S. Agro, MD, *Vice-Chairman* Haddonfield
 Michael M. Heeg, MD, *Vice-Chairman* Trenton
 Palma E. Formica, MD Old Bridge
 Julie M. Fortunato, MD Westwood
 Carl Restivo, Jr, MD Jersey City
 B. Ralph Wayman, Jr, MD Yardley, PA

Marion Geib, *Auxiliary Member* Haddonfield
 Gerald H. Rozan, MD, *Ex-Officio Member* Wayne

Committee on Medicaid

(Joseph C. Lucci, Staff Liaison)

Churchill L. Blakey, MD, *Chairman* Wenonah
 James Q. Atkinson, MD Vincentown
 Thomas S. Bellavia, MD Hasbrouck Heights
 Gertrude B. Brundage, MD East Orange
 Anthony J. DiCroce, MD Point Pleasant Beach
 Louis G. Fares, MD Trenton
 Anton P. Kemps, MD Camden
 Sheldon Lang, MD Passaic
 Arganey L'Avnir Lucas, Jr, MD Morristown
 Bernard A. Pekala, MD Cherry Hill
 William Silverman, MD Cape May Court House
 John M. Payan, *Student Member* Passaic
 Murray Pine, DO, *Consultant* Newark
 I. Fulton Erlichman, MD, *Invited Guest* Trenton
 Thomas Russo, *Invited Guest* Trenton
 S. Eugene Yuliano, MD, *Invited Guest* Trenton

Committee on Medical Education

(Martin E. Johnson, Staff Liaison)

Bernardo Toro-Echague, MD,
Chairman Scotch Plains
 David E. Sweet, MD,
Vice-Chairman New Brunswick
 Leonard Bielory, MD Springfield
 William C. Black, MD Hackensack
 John C. Brogan, MD Flemington
 Sherman Garrison, MD Bridgeton
 Brewster S. Miller, MD Somerville
 Paul C. Royce, MD Long Branch
 Bessie Sullivan, MD Edison
 Sanford H. Vernick, MD, PhD Holmdel
 Stephen F. Wang, MD Morristown

Mary Willard, MD Voorhees
 Peg Reichwein, *Auxiliary Member* Pennsville
 Jay S. Rothberg,
Student Member Cherry Hill
 David L. Dickerman,
Alternate Student Member Somerset
 Alfred A. Alessi, MD, *Consultant* Oradell
 Dryden Morse, MD, *Consultant* Browns Mills
 Nathan F. Troum, MD, *Consultant* Bayville
 William S. Vaun, MD, *Consultant* Colts Neck

Committee on Medical Student Loan Fund

Arthur White, Staff Liaison)

David J. Greifinger, MD, *Chairman* Belleville
 Harry M. Carnes, MD Audubon
 Theodora J. Maio, MD Clifton
 Robert M. Pickoff, MD New Brunswick

Committee on Membership Services

Joseph C. Lucci, Staff Liaison)

Harvey P. Yeager, MD, *Chairman* West Orange
 John D. Franzoni, MD,
Vice-Chairman Trenton
 William H. Ainslie, Sr, MD Metuchen
 Angelo S. Agro, MD Haddonfield
 Donald J. Cinotti, MD Jersey City
 Ernest C. Hillman, Jr, MD Glen Ridge
 Stanley Karp, MD Cinnaminson
 Robert L. Maggs, MD Holmdel
 Nicholas E. Marchione, MD Vineland
 Paul R. Megibow, MD Fort Lee
 Martin L. Sorger, MD Glen Ridge
 John J. Sprowls, MD Rahway
 Robert C. Steeb, MD Camden
 Eloise A. Logio,
Auxiliary Member Mountainside
 E. Arthur Kratzman, MD, *Consultant* Jamesburg
 Jesse Schulman, MD, *Consultant* Lakewood
 Bernard Robins, MD, *Ex-Officio Member* Union

SPECIAL COMMITTEES

Committee on Biomedical Ethics

June O'Hare, Staff Liaison)

Robert L. Pickens, MD, *Chairman* Princeton
 Joseph F. Fennelly, MD, *Vice-Chairman* Madison
 Robert Bayly, MD Plainfield
 Deborah A. Beiter, MD Somerville
 Reverend Charles Brown, MD, JD Flanders
 Arnold Byer, MD Hackensack
 Roger C. Duvoisin, MD New Brunswick
 John S. Madara, MD Salem
 Louis G. McAfoos, Jr, MD Westmont
 Charles J. Moloney, MD Moorestown
 Herman M. Robinson, MD Livingston
 Rudolf E. Schwaeble, MD Mendham
 J. Bernard Winkler, MD Wayne
 John Winslow, MD South Orange
 Katherine H. Zimmerman, MD Mountain Lakes
 Angie Campo, *Auxiliary Member* Lawrenceville
 Thea Appelbaum, *Student Member* Livingston

Committee on Publication

(Geraldine Hutner, Staff Liaison)

Harry M. Carnes, MD, *Chairman* Audubon
 Richard M. Ball, MD South Plainfield
 William V. Harrer, MD Camden
 Monroe S. Karetzky, MD Newark
 Avrum L. Katcher, MD Flemington
 Clement H. Kreider, Jr, MD Ocean
 John H. Lifland, MD Bridgewater
 Alan J. Lippman, MD Newark
 Robert M. MacMillan, MD Philadelphia, PA
 Helio J. Malinverni, MD Manahawkin
 Donald W. Orth, MD Voorhees
 Leon G. Smith, MD Essex Fells
 Morris Soled, MD Jersey City
 Louis S. Zeiger, MD Camden
 LaVerne Fioretti, *Auxiliary Member* Paramus
 Leonard Saltzman, *Student Member* Fair Lawn
 Douglas M. Costabile, MD,

Ex-Officio Member Murray Hill
 Bernard Robins, MD, *Ex-Officio Member* Union
 Howard D. Slobodien, MD,

Ex-Officio Member Metuchen

Committee on Revision of Constitution and Bylaws

(Diana C. Gore, Staff Liaison)

James E. George, MD, JD, *Chairman* Woodbury
 William Greifinger, MD,
Vice-Chairman South Orange
 William A. Allgair, MD South River
 Michael M. Heeg, MD Trenton
 Maceo Howard, MD Jersey City
 Andrew Kunish, MD Fair Lawn
 Kenneth N. Kunzman, MD Somerville
 Pascal A. Pironti, MD Summit
 Bernardine Moloney, *Auxiliary Member* Moorestown
 Hillel M. Ben-Asher, MD, *Consultant* Morristown
 Henry J. Mineur, MD, *Consultant* Westfield
 Bernard Robins, MD, *Ex-Officio Member* Union

Ron Tharp, *Alternate Student Member* Trenton
 Paul Armstrong, Esq, *Consultant* Bridgewater
 Joseph A. Cox, MD, *Consultant* Short Hills
 Edmund L. Erde, PhD, *Consultant* Camden
 Russell L. McIntyre, ThD, *Consultant* Piscataway
 Geraldine Moon, *Consultant* Princeton
 Mary Strong, *Consultant* Summit

Committee on Cancer Control

(Joseph C. Lucci, Staff Liaison)

George J. Hill, MD, *Chairman* Newark
 Susan A. McManus, MD,
Vice-Chairman New Brunswick
 Alice J. Cohen, MD Newark
 Lawrence J. Ettinger, MD New Brunswick
 Daniel Frimmer, MD Somerset
 Ralph S. Greco, MD New Brunswick
 Thomas C. Hall, MD Newark
 Bernard J. Kulper, MD Scotch Plains

Albert A. Pineda, MD Clifton
 Thomas F. Rocereto, MD Haddonfield
 Harvey D. Rothberg, MD Princeton
 Elissa J. Santoro, MD Livingston
 Donald K. Sass, MD Millville
 Norman H. Siegel, MD Hammonton
 Eva B. Stahl, MD Highland Park
 Harvey P. Yeager, MD West Orange
 Neil Kaplitz, *Student Member* Montclair
 Maano Milles, DDS, *Consultant* Newark
 George Yamane, DDS, *Consultant* Newark

Committee on Conservation of Vision
 (Joseph C. Lucci, Staff Liaison)

Alfonse A. Cinotti, MD, *Chairman* Jersey City
 Carl P. Bontempo, MD Long Branch
 Vivian Chen, MD East Brunswick
 Joseph M. Kaspareck, Jr, MD Somerville
 Thomas I. Rozanski, MD Sewell
 Ralph A. Skowron, MD Cherry Hill
 Saul M. Tischler, MD Cherry Hill
 Daniel B. Goldberg, MD, *Consultant* Long Branch

Committee on Emergency Medical Care
 (Joseph C. Lucci, Staff Liaison)

Rudolf E. Schwaeble, MD, *Chairman* Mendham
 John A. Flood, Jr, MD, *Vice-Chairman* Trenton
 Clifford B. Blasi, MD Sea Girt
 Richard T. Cook, Jr, MD Berlin
 Joseph R. Friedlander, MD River Edge
 C. Clayton Griffin, MD Newark
 Jack R. Karel, MD Hackensack
 J. Mark Meredith, MD Chatsworth
 Dorson S. Mills, MD Elmer
 Nelson C. Walker, MD Hackensack
 Todd M. Warden, MD Haddonfield
 Robert L. Wegryn, MD Elizabeth
 Michael Bavlsik, *Student Member* Piscataway
 Joseph Kavanaugh, *Consultant* Martinsville
 Henry R. Liss, MD, *Consultant* Chatham
 Robert R. Scussel, *Consultant* Trenton
 Joseph F. Slavin, *Consultant* Princeton

Committee on Environmental Health
 (Joseph C. Lucci, Staff Liaison)

Stanley R. Lane, MD, *Chairman* Moorestown
 Morris I. Brodkey, MD Toms River
 Daniel N. Burbank, MD Cedar Grove
 J. Gerard Crowley, MD Somerville
 Kenneth P. Lipkowitz, MD Howell
 Richard H. Musnug, MD Medford Lakes
 Philip J.G. Quigley, MD Greenwich
 James N. Suddeth, MD Beach Haven
 John M. Tedeschi, MD Collingswood
 Christopher F. Schultz,
Student Member Toms River
 Richard S. Thomas, *Student Member* Garfield

Committee on Graduates of Non-U.S. Medical Schools
 (Martin E. Johnson, Staff Liaison)

Sheldon Guss, MD, *Chairman* Bound Brook

Burton M. Feinsmith, MD,
Vice-Chairman Westfield
 Carlos P. Borromeo, Jr, MD Pennsauken
 Frank Campo, MD Lawrenceville
 Shah M. Chaudhry, MD Cape May Court House
 Joseph M. DeBlasio, MD Trenton
 Leticia V. DeCastro, MD Edison
 William L. Diehl, MD Morristown
 Pietro Enzo DiFlorio, MD Haddonfield
 Gino Gonnella, MD Edison
 Guillermo J. Garcia, MD Jersey City
 Philip J. Jasper, MD Passaic
 Andrew Kunish, MD Fair Lakes
 Mohan C. Makhija, MD Long Branch
 Richard A. Michner, MD Cape May Court House
 S. Desiderio Penso, MD Brigantia
 Kutumba S. Pitta, MD Toms River
 Carlo Porcaro, MD Newark
 Celia G. Roque, MD Cranford

Committee on Long-Range Planning and Development
 (A. Ronald Rouse, Staff Liaison)

Bernard A. Rineberg, MD,
Chairman New Brunswick
 Charles S. Krueger, MD,
Vice-Chairman Mount Hope
 Mary Blome, MD Cresskill
 Donald K. Brief, MD Millburn
 Robert Eidus, MD Westfield
 George Leipsner, MD Maywood
 Eileen M. Moynihan, MD Woodbury
 Fred M. Palace, MD Morristown
 Andrea I. Reznick, MD Bridgewater
 Gabriel F. Sciallis, MD Mercerville
 Jane Lorber, *Auxiliary Member* Scotch Plains

Committee on Maternal and Child Care
 (Joseph C. Lucci, Staff Liaison)

Thomas A. Noone, MD, *Chairman* Haddonfield
 Gerard F. Hansen, MD,
Vice-Chairman Hackensack
 Peter A. Beaugard, MD Flemington
 Thomas F. Bejgrowicz, MD Linderooth
 Stephen M. Golden, MD Summit
 Caterina A. Gregori, MD Livingston
 John T. Harrigan, MD New Brunswick
 Thomas Hegyi, MD New Brunswick
 I. Mark Hiatt, MD New Brunswick
 Ruby P. Huttner, MD Flemington
 Glenn P. Lambert, MD Flemington
 Courtney M. Malcarney, MD Collingswood
 James P. Thompson, MD Clifton
 Andrew Bush, *Student Member* Wood Ridge
 Edith Goldie,
Alternate Student Member Roselle Park
 George J. Halpin, MD, *Consultant* Trenton

Committee on Medical Aspects of Sports
 (Joseph C. Lucci, Staff Liaison)

Vincent K. McInerney, MD, *Chairman* Paterson
 Stuart A. Hirsch, MD, *Vice-Chairman* ... Bridgewater

Allan M. Levy, MD, *Vice-Chairman* Westwood
 Brian C. Halpern, MD Princeton
 Christine E. Haycock, MD Newark
 Timothy M. Hosea, MD New Brunswick
 Glenn P. Lambert, MD Flemington
 Richard Levandowski, MD Pennington
 Warren F. MacDonald, Jr, MD

..... Cape May Court House
 Joseph P. Pizzurro, MD Ridgewood
 Gary J. Savatsky, MD Paramus
 David I. Scott, MD Piscataway
 Aaron A. Sporn, MD Mercerville
 David A. Stone, MD East Rutherford
 Steven G. Crawford, MD,

Resident Member Neptune
 Peter Gusmer, *Student Member* Short Hills
 Ron Noy,

Alternate Student Member Fair Lawn
 John Culberson,

Alternate Student Member Bridgewater
 Abner West, *Consultant* Short Hills
 Donald Williams, *Consultant* Pennington
 Joyce Williams, *Consultant* Pennington

Committee on Physicians' Health

(David I. Canavan, MD, Staff Liaison)

Thomas J. Liddy, MD, *Chairman* Livingston
 Robert Altin, MD Cherry Hill
 William J. Annitto, MD Rancocas
 James A. Barnshaw, MD Princeton
 Ann Beams Cranford
 Natalie I. Bilenki Morris Plains
 Joseph Campagna, MD Summit
 David I. Canavan, MD Lawrenceville
 A. Vincent DeRobbio, MD Newark
 Ronald I. Forster, MD Union
 Daniel P. Greenfield, MD Short Hills
 Boris G. Iovovich, MD Annandale
 Glenn Jacoby, MD Bound Brook
 Charles Kastenber, DO Cherry Hill
 Doulat Keswani, MD Ridgewood
 Herbert J. McBride, MD Toms River
 Nancy McBride Toms River
 George J. Mellendick, MD Perth Amboy
 Joseph L. Mooney, MD Trenton
 Simon D. Murray, MD Princeton
 John J. Naughton, DO Cinnaminson
 John J. Verdon, Jr, MD Tinton Falls
 Robert M. Warden, DO Stratford

Committee on Senior Citizens

(A. Ronald Rouse, Staff Liaison)

Ian Samson, MD, *Chairman* Lakewood
 William A. Allgair, MD South River
 Joseph W. Bitsack, MD Hackensack
 Churchill L. Blakey, MD Wenonah
 Donald J. Cinotti, MD Jersey City
 Natalio Damien, MD Red Bank
 Ralph J. Fioretti, MD Rochelle Park
 Seymour N. Herschberg, MD Trenton
 Michael D. Horn, MD Willingboro

Philip J. Jasper, MD Passaic
 Joseph J. Kinney, MD Bridgewater
 John P. Kohler, MD Camden
 A. Ralph Kristeller, MD Millburn
 Emmons G. Paine, MD Voorhees Township
 Marc I. Rothman, MD Cherry Hill
 Robert I. Salasin, MD Cape May Court House
 Teresa Schaer, MD New Brunswick
 Andrew B. Weiss, MD Roseland
 William I. Weiss, MD Livingston
 Harry M. Woske, MD Flemington
 Michael Bavlisk, *Student Member* Piscataway
 Mary Jane Brubaker, *Consultant* East Brunswick

Committee on Utilization Review Systems

(Vincent A. Maressa, Staff Liaison)

Robert J. Weierman, MD, *Chairman* .. South Orange
 Lawrence L. Livornese, MD,

Vice-Chairman Middlesex
 Malcolm G. Coblenz, MD Livingston
 Alfio G. Dal Pan, MD Fair Lawn
 Bernard Gardner, MD Hackensack
 Howard J. Goldson, MD Bound Brook
 George T. Hare, MD Haddon Heights
 A. Ralph Kristeller, MD Millburn
 Ralph J. Lewis, MD New Brunswick
 Eugene Joseph Lind, MD West Orange
 John J. LoCurto, Jr, MD Hackensack
 Emmons G. Paine, MD Voorhees Township
 Irving P. Ratner, MD Willingboro
 Benjamin F. Rush, Jr, MD Newark
 Ira M. Rutkow, MD Freehold
 William A. Sweeney, MD New Brunswick
 Elias N. Tsoukas, MD Ramsey

Committee of Young Physicians

(A. Ronald Rouse, Staff Liaison)

Joseph P. Calderone, Jr, MD Cranford
 Reid A. Lachman, MD Morristown
 Kevin Basralian, MD Rutherford
 Donald J. Cinotti, MD, *Chairman* Jersey City
 Timothy M. Hosea, MD,

Vice-Chairman New Brunswick
 Madeline M. Manzione, MD Lawrenceville
 Dale E. Edlin, MD Holmdel
 John E. Gatti, MD Cherry Hill
 David M. MacPeck, MD Lakewood
 James P. O'Neill, MD Avon-by-the-Sea
 Todd Warden, MD Camden
 Jorge A. Prieto, MD Woodbury
 Richard K. Gadon, MD Hammonton
 Joel Braver, *Student Member* Somerset
 John Kurek, *Alternate Student Member* . Lindenwold
 C. Clayton Griffin, *Member-at-Large* Newark

Committee on Women in Medicine

(A. Ronald Rouse, Staff Liaison)

Patricia G. Klein, MD, *Chairman* Westwood
 Mary Blome, MD Englewood
 Gertrude B. Brundage, MD East Orange
 Christina Y. Chao, MD Medford

Leticia V. DeCastro, MD Edison
 Janet I. Geraghty-Deutsch, MD Jersey City
 Wendy Martinez, MD Cherry Hill
 Ligaya L. Prystowsky, MD Passaic
 Rose P. Prystowsky, MD Nutley
 Andrea I. Reznik, MD Bridgewater
 Celia G. Roque, MD Cranford
 Catherine E. Spears, MD Chatham
 Bessie M. Sullivan, MD Edison
 Carolyn W. Watson, MD Glen Ridge
 Suzanne A. Widrow, MD Hanover

Task Force on AIDS

(A. Ronald Rouse, Staff Liaison)

Leon G. Smith, MD, *Chairman* Essex Fells
 Dennis P. Quinlan, MD,
Vice-Chairman South Orange
 David J. Gocke, MD New Brunswick
 Alvin I. Kaplan, MD Bound Brook
 Anthony B. Minnefor, MD Paterson
 Charles J. Moloney, MD Moorestown
 Joseph J. O'Connor, MD West Orange
 Robert L. Pickens, MD Princeton
 Irving P. Ratner, MD Willingboro
 Paul H. Steel, MD Atlantic City
 Joan Gering, *Auxiliary Member* Lambertville
 Richard Brennan, Esq, *Consultant* Morristown
 Ronnie Davidson, EdD, *Consultant* Lawrenceville
 Dorothy Flemming, MSN, RN,
Consultant Trenton
 Charles Heitzmann, *Consultant* Lawrenceville
 Edward Johnson, MD, *Consultant* Newark
 Rajendra Kapila, MD, *Consultant* Newark
 R. Don King, MD, *Consultant* Newark
 Florence Kortis, *Consultant* Clifton
 Katherine Kuren, RN, *Consultant* Newark
 Otto G. Matheke, MD, *Consultant* Newark
 Frank Michalski, MD, *Consultant* Teterboro
 James Oleske, MD, *Consultant* Newark
 Elena Perez, *Consultant* Newark
 George Perez, MD, *Consultant* Newark
 Richard C. Reed, MD, *Consultant* Trenton

John Sensakovic, MD, *Consultant* Newark
 Whaijen Soo, MD, PhD, *Consultant* Nutley
 Diane Stager, *Consultant* Princeton
 Anthony Tarasenko, MD, *Consultant* Newark
 Neil Williams, MD, *Consultant* Trenton

Task Force on the Shortage of Nurses and Technical Personnel

(Vincent A. Maressa, Staff Liaison)

John S. Madara, MD, *Chairman* Sales
 Stanley S. Bergen, Jr, MD Newark
 Arthur Bernstein, MD South Orange
 Barry A. Cohen, MD Wayne
 Fred M. Palace, MD Morristown
 Harold R. Reeve, MD Mt. Holly
 Stephen R. Shapiro, MD Somerville
 Ralph A. Skowron, MD Cherry Hill
 Harold S. Yood, MD Plainfield
 Lynn O'Malley, RN, *Auxiliary Member* Moorestown
 Karen Putterman, MD, MPH,
Alternate Member Newark
 Frances W. Quinless, RN, PhD,
Alternate Member Newark
 Elizabeth A. English, *Consultant* Old Bridge
 Jean R. Marshall, RN, *Consultant* Trenton
 Pauline McDuffy, LPN, *Consultant* Piscataway
 Geraldine Moon, *Consultant* Princeton
 Linda Tondow, *Consultant* Princeton
 Barbara W. Wright, RN, *Consultant* Trenton
 Mary Anne Yeager, *Consultant* Trenton

Task Force on Uncompensated Care for Physicians

(Joseph C. Lucci, Staff Liaison)

John C. Baker, MD, *Chairman* Northfield
 James E. Barone, MD Trenton
 Churchill L. Blakey, MD Wenona
 John P. Capelli, MD Haddonfield
 William R. Chenitz, MD Newark
 Floyd J. Donahue, MD Elizabeth
 Walter J. Pedowitz, MD Linden
 Robert S. Rigolosi, MD Teaneck

HOUSING APPLICATION

**224th ANNUAL MEETING
MEDICAL SOCIETY OF NEW JERSEY
MAY 6-9, 1990**

Select the hotel of your choice. Mail the entire form with one night's deposit to that hotel.

THE SANDS HOTEL, CASINO & COUNTRY CLUB (Headquarters Hotel)
INDIANA AVE. AT BRIGHTON PARK, P.O. BOX 28, ATLANTIC CITY, NJ 08404
RESERVATION DEPARTMENT 1-800-257-8580

(Please Print)

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Sharing With _____

Date of Arrival _____ Time _____

Date of Departure _____ Time _____

A one-night deposit (equivalent to room rate) is required with all reservation requests. Please send check or money order payable to the **SANDS** or complete the following:

American Express No. _____ Expiration Date _____

SCHEDULE OF RATES SUBJECT TO 12% TAX

☐ SINGLE \$75.00 ☐ One-Bedroom Suite \$225.00 ☐ Two-Bedroom Suite \$300.00

☐ DOUBLE \$75.00 (Reservations must be received prior to April 6, 1990)

Check-out time is 12 Noon. Rooms may not be available for check-in until after 3 p.m. Check-in time on Sundays is 6 p.m. FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION is required for a full refund.

PARKING: FREE PARKING TO REGISTERED GUESTS. One car per room.

☐ Check if Official Delegate County _____

CLARIDGE CASINO HOTEL

INDIANA AVE. AT THE BOARDWALK, P.O. 448, ATLANTIC CITY, NJ 08404
RESERVATION DEPARTMENT (609) 340-3434
NJ ONLY 1-800-582-7676

(Please Print)

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Sharing With _____

Date of Arrival _____ Time _____

Date of Departure _____ Time _____

A one-night deposit (equivalent to room rate) is required with all reservation requests. Please send check or money order payable to the **CLARIDGE** or complete the following:

Card # _____ Type _____ Exp. Date _____

SCHEDULE OF RATES SUBJECT TO 12% TAX

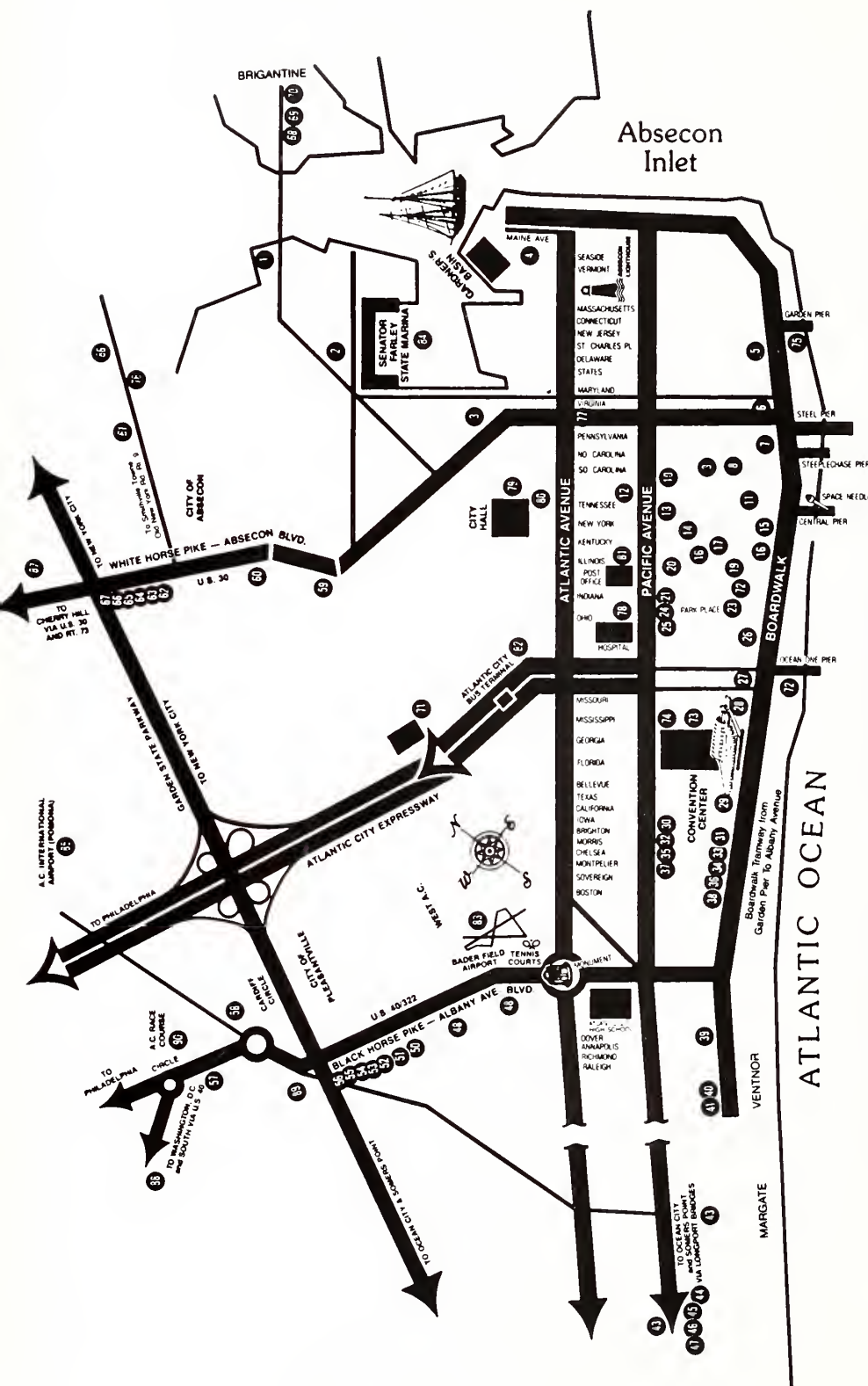
☐ SINGLE \$75.00 ☐ One-Bedroom Suite \$225.00 ☐ Two-Bedroom Suite \$300.00

☐ DOUBLE \$75.00 (Reservations must be received prior to April 5, 1990)

Check-out time is 12 Noon. Rooms may not be available for check-in until after 3 p.m. Check-in time on Sundays is 6 p.m. FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION is required for a full refund.

PARKING: FREE PARKING TO REGISTERED GUESTS. One car per room.

☐ Check if Official Delegate County _____



GREATER ATLANTIC CITY HOTELS/MOTELS/POINTS OF INTEREST

1. Harrah's Marina
2. Trump Castle
3. Admiral's Quarters**
4. Radisson Flagship Resort**
5. Snowboat
6. Trump Taj Mahal*
7. Resorts International
8. Barbizon-Catalina
9. Carolina Crest
10. Quality Inn
11. Trinidad
12. Fiesta
13. Envoy
14. Econo Lodge Boardwalk
15. Atlantic Palace**
16. La Renaissance**
17. Casino Beach
18. Continental
19. Continental
20. Bala
21. Midtown Motor Inn
22. Sands
23. Claridge
24. Best Western - Atlantic City
25. Royal Inn
26. Bally's Park Place
27. Caesars Atlantic City
28. Trump Plaza
29. Atlantis
30. Ascot
31. TropWorld
32. Dunes
33. Days Inn - Atlantic City
34. Diplomat
35. International
36. Ocean Club**
37. Casino Beach
38. Bally's Grand
39. Bally's Grand
40. Oceanaire (Ventnor)
41. Mayfair By-The-Sea (Ventnor)
42. White Sands (Margate)
43. Residence Inn (Somers Point)
44. Impala Motel (Ocean City)
45. Santa Barbara (Ocean City)
46. Port-O-Call (Ocean City)
47. Crossings Motor Inn
48. Ocean City
49. Airport Motor Inn
50. Best Western Inn at Golf & Tennis World
51. Hampton Inn West
52. Pleasantville Motor Inn
53. Sheraton Inn
54. Whittier Inn
55. Whittier Inn
56. Days Inn - Pleasantville
57. Red of the Dove (Cardiff)
58. Red Carpet Inn (Cardiff)
59. Howard Johnson Hotel
60. Comfort Inn North
61. Marriott's Seaview Golf Resort
62. Travel Lodge
63. Econo Lodge
64. Budget Host Inn
65. Hampton Inn Hotel
66. Days Inn Absecon
67. Travel Inn
68. Islander (Brigantine)
69. La Sammana (Brigantine)
70. The Sea Gull (Brigantine)
71. Atlantic City Rail Terminal and Site Of New Convention Center
72. Atlantic City Convention Center
73. Atlantic City Convention Center
74. Atlantic City Convention & Visitors Bureau
75. Atlantic City Art Center
76. Natl. Wildlife Refuge & Noyes Museum
77. Gordon's Alley Shops
78. City Hall
79. Hospital
80. Public Library
81. Post Office
82. Bus Station
83. Bader Field Airport
84. Sen. Frank S. Farley State Marine
85. Atlantic City
86. International Airport
87. Historic Smithville & Village Greene
88. Historic Wheaton Village
89. Shore Mall/Boscova
90. Atlantic City Race Course & Hamilton Mall/Macy's

*Under construction/Casino Hotel Pending, N.J. Licensee

**Condo



NOTEBOOK

TRUSTEES' REPORT

A meeting of the Board of Trustees was held on September 7, 1989, at the executive offices in Lawrenceville. Detailed minutes are on file with the secretary of our county society. A summary of significant actions follows:

Audit Review Committee . . . The following recommendations were approved:

That the audited financial statements be accepted and a copy thereof forwarded to each component society.

That Ernst & Whinney be continued as the external auditors.

Congresswoman Roukema . . . Was introduced to Representative Marge Roukema, from the fifth congressional district since 1980; topics of discussion included: budget problems, cost controls, and the catastrophic illness insurance bill.

Report of the President . . .

(1) Special Dates . . . Noted the following meeting dates: September 27 for the Executive Committee and the New Jersey Congressional Delegation; October 4 for the Board legislative session with state legislators; November 9 for Doctor James S. Todd to attend the Board meeting; November 15 for the Conference of Presidents for presidents and presidents-elect of county and specialty societies and presidents of hospital medical staffs; and March 9-10 for the Strategic Planning Retreat.

(2) Appointments . . . Noted the following appointments: Doctor John C. Baker as chairman of the Task Force on Uncompensated

Care for Physicians; and Karl T. Franzoni as chairman of AMA Reference Committee "F."

(3) JEMPAC . . . Was mailed a listing of the 1989 JEMPAC membership by county and noted that a list of the Trustees and members of the AMA Delegation who have joined JEMPAC will be distributed shortly.

(4) MSNJ Auxiliary Voter Registration Project . . . Expressed appreciation to the Auxiliary for their voter registration project the week of September 17.

(5) Virginia Apgar Award . . . Extended congratulations to Dr. Palma E. Formica, one of the recipients of the 1989 Virginia Apgar Award for New Jersey Women of Achievement.

(6) Sports Medicine Program . . . Noted the sports medicine program on October 18, open to physicians, nurses, coaches, school administrators, athletic directors, and trainers.

(7) Letter to Nonmembers of Bergen County Medical Society . . . Noted the effort by Bergen County Medical Society to encourage membership by inviting nonmembers to discuss their concerns.

(8) Academy of Medicine of New Jersey Board of Trustees . . . Announced the appointment of Drs. Sherman Garrison, Edwin W. Messey, and Bernard Robins to the AMNJ Board of Trustees.

(9) AMA Advisory Committee on Foreign Medical Graduates . . . Voted to endorse the nomination of Frank Campo, MD, to the Committee.

(10) AMA Council on Legislation . . . Noted that Dr. Edward

A. Schauer will seek appointment to the AMA Council on Legislation.

Report of Executive Director . . .

(1) MSNJ Paid Memberships . . . Noted that as of August 31, 1989, there were 60 less paid memberships than reported on that date last year, and an internal review will be made to determine the reason.

(2) MSNJ Financial Statements . . . Approved the financial statements for the period ending July 31, 1989.

(3) New Jersey History of Medicine and Pharmaceutical Industries . . . Granted permission to solicit external funding to produce the program on medicine and pharmaceutical development in New Jersey by MSNJ.

(4) Medical Discipline and Licensing—S-2936 . . . Requested an additional amendment, but there is no feedback from the Assembly Committee as to whether it will be accepted; regardless, the bill is acceptable to MSNJ in its present form.

(5) Medical Malpractice Surcharge . . . Noted that the rescheduled hearing on the commissioner's charge ruling will be held on September 22.

(6) Special Assessment . . . (a) Noted the suit filed by Doctor Clemente, because of the omission of his name from the *Directory* for nonpayment of the special assessment, has been reinstituted; (b) noted that the 288 members who did not pay the special assessment will be billed again and names of members not paying will be published in *NEW JERSEY*

MEDICINE; and (c) noted a supplement to the *Membership Directory* will be published.

(7) Medical Waste Regulation . . . Authorized participation in the Small Medical Waste Generator Coalition in opposing the regulation of the Department of Environmental Protection.

(8) Medicare Status Report . . . Received a written report on the status of the Medicare transition including information on claims; ICD-9 coding; referring physician identifier numbers; assistant at surgery; specific case referrals; and aggregated statistics.

(9) Burdette Tomlin Memorial Hospital Obstetrical Services . . . Received a report from Dr. Riggs stating he did not find any deficiencies in the obstetrical/gynecological department.

(10) In Re Sinha . . . Noted the case (involving the suspension of the license of Dr. Sinha, an anesthesiologist, by the State Board of Medical Examiners) now is at the Supreme Court and all parties have filed their briefs.

(11) Trentonian Article . . . Agreed that a response to an article about unfit doctors was unnecessary.

UMDNJ Report . . . Received a written report from Stanley S. Bergen Jr, MD, commenting on the following: Ruy Z. Lourenco, MD, as the new dean of the New Jersey Medical School; approval of proposal to develop a school of nursing; the rise of minority enrollment at UMDNJ; opening of the dental clinic in Newark for persons suffering from acquired immunodeficiency syndrome; an amicus curiae position taken by UMDNJ, AMA, and the American Hospital Association on a case involving the refusal of the Supreme Court of Missouri to accept the wishes of a family to withdraw life-support systems from a young woman who has been in a vegetative state for over two years; development of a clinical skills examination; a stu-

dent option to take the traditional FMGEMS or part one and part two of the National Board examination (both are identical except for the length); absorption of all students accepted at Fairleigh Dickinson at UMDNJ-New Jersey Dental School; and the availability of an exhibit of pioneer women physicians for interested organizations.

State Board of Medical Examiners . . . Received the following report from Michael B. Grossman, DO, president of SBME: affirmation of commitment to communication and cooperation between SBME and MSNJ; upcoming announcement of medical director for SBME; the SBME hardline position on doctors who dispense drugs inappropriately; investigation regarding first assistants for major surgery; filing of the amicus brief in the physical therapy case; proposal by MSNJ to receive renewal permits for CDS prescriptions in April; discussion of SBME requirements for premedical education; comments on A-4284 (sets up a separate Board of Chiropractic Examiners); and the State Board's actions regarding fee complaints.

Council on Legislation . . .

(1) S-3440—Generic Substitution/Prescription Blank Change . . . Approved the following:

That the Board of Trustees reverse its position of No Action to one of Active Opposition on S-3440.

(2) S-722 through S-727—Insurance Benefits; Psychiatric Care . . . Will postpone action until next meeting.

(3) Current State Legislation . . . Approved the following:

That the Board of Trustees approve the positions recommended by the Council on Legislation.

(4) S-3429—Commissioner of Health . . . Approved the position of active opposition to this bill that

would delete the requirement of medical license to be commissioner of health.

Committee on Annual Meeting . . .

(1) Schedule of Future Annual Meetings . . . Noted the Committee did not find it feasible to compress the number of days of the Annual Meeting.

(2) 1990 Annual Meeting Site . . . Approved the following:

That the 224th Annual Meeting held at the Sands Hotel, Casino and Country Club in Atlantic City, New Jersey, on Sunday, May 6 through May 9, 1990. (The Claridge Casino Hotel will serve as coheadquarters)

(3) Daily Schedule . . . Approve the following:

That the Board of Trustees approve the proposed daily schedule for the 1990 Annual Meeting (see page 901)

Task Force on AIDS . . . Referred back to the Task Force their recommendation concerning a central person to oversee the AIDS epidemic.

Ad Hoc Committee on Women . . . Approved the following:

That the status of the Ad Hoc Committee on Women in Medicine be changed to a permanent committee of the Society.

Task Force on the Shortage of Nurses and Technical Personnel . . .

(1) Interim Report of the Board . . . Adopted as amended the recommended policies (deletion of words "to act independently in policy letter 'I'":

(a) The Registered Care Technician (RCT) proposal of the AMA should not be implemented in New Jersey at this time. (This position was adopted by the Board of Trustees at its meeting on October 16, 1988.)

(b) Nurses' salaries should be competitive with contiguous states and realistic adjustments must be made.

(c) Communication and collaboration between physicians and nurses should be strongly encouraged. Nurses

should have authority commensurate with their accountability in rendering patient care. Physician input from their aspect of daily practice is essential to the total endeavor to promote good patient care in hospitals.

(d) Nurses should be relieved of non-nursing functions and guidelines should be implemented to reduce the time spent in superfluous documentation on patient and hospital records.

(e) Funding (at a cost of \$100,000 for a one-year pilot program) should be

sought for implementation of the Acute Care Nursing Assistant (ACNA) Program proposed by the University of Medicine and Dentistry of New Jersey's Department of Nursing Education and Services, and endorsed by the Medical Society of New Jersey (Board of Trustees' meeting October 16, 1988) and the New Jersey Hospital Association as a method to relieve the task load of professional nurses in acute care institutions. Possible sources of funding for this endeavor are:

(1) The \$20 million incentive reimbursement program established by the New Jersey Department of Health for restructuring the delivery of nursing services at selected hospitals.

(2) Public and/or private grants awarded on a competitive basis.

(f) The New Jersey Hospital Association's Nursing and Allied Health Resource Center should be supported as an information clearinghouse and referral source for individuals interested in nursing and allied professions.

(g) Health career scholarships and tuition forgiveness programs should be encouraged for individuals interested in nursing and allied health careers. Component medical societies, auxiliaries, and local hospitals should offer scholarships and loan programs for nursing and allied health personnel that would offer a career ladder in the health professions.

(h) Sufficient support personnel must be provided so that nurses can focus on providing, supervising, and coordinating quality nursing care. Licensed practical nurses (LPNs) should be utilized at all levels of hospital care—they should be permitted to perform such additional patient care procedures as defined by the expanded scope of practice permitted by the State Board of Nursing, thus providing a continuity of care often lacking.

(i) In order to facilitate retention of graduate nurses who fail their board examinations, a means should be found to extend their work permits, with limitations, to allow them to function in the graduate nurse capacity, until they retake their board examinations.

(j) Retention also should be enhanced by improving the environmental factors which place an unbearable workload on the bedside nurse. Hospitals should be encouraged to provide child care for women returning to the workplace, and extra pay for the more difficult or least desirable shifts. Bedside nursing requires night, weekend, and holiday work schedules.

(k) Monies should be made available to provide hospitals with sufficient reimbursement funds to recruit and retain allied health personnel, such as ultrasonographers, nuclear medicine technicians, respiratory technologists, x-ray technologists, radiation therapy technologists, physical therapists, and medical records workers.

Educational opportunities, with flexible and innovative programs (such as evening refresher courses), scholarship programs, and long-term agreements should be offered to attract

1990 MSNJ ANNUAL MEETING

Saturday, May 5, 1990

3:30 p.m. Board of Trustees' Meeting

7:00 p.m. Officers' Cocktail Reception and Dinner

Sunday, May 6, 1990

8:00 a.m. Registration Opens

8:00 a.m. Message Center Opens

10:00 a.m. Educational Program

11:00 a.m. Exhibits Open

1:00 p.m. House of Delegates

3:30 p.m. Reference Committee Meetings

Monday, May 7, 1990

8:00 a.m. Registration Opens

8:00 a.m. Message Center Opens

8:30 a.m. Exhibits Open

9:00 a.m. House of Delegates (Election)

12:00 noon Golden Merit Award Ceremony and Reception

1:00 p.m. Professional Liability Program (MIIENJ)

2:45 p.m. Reference Committee Meetings

5:00 p.m. JEMPAC Political Forum

5:45 p.m. JEMPAC Wine and Cheese Reception

6:30 p.m. Somerset County Medical Society

Tuesday, May 8, 1990

8:00 a.m. Registration Opens

8:00 a.m. Message Center Opens

8:30 a.m. Exhibits Open

9:00 a.m. House of Delegates

1:30 p.m. House of Delegates

2:00 p.m. Exhibits Close

6:30 p.m. Inaugural Reception and Dinner

Wednesday, May 9, 1990

8:00 a.m. Registration Opens

8:00 a.m. Message Center Opens

8:30 a.m. General Session

1:00 p.m. Board of Trustees' Meeting

people into the fields of nursing and allied health, and to encourage those who have left to return. Retention of students should be encouraged by setting higher standards to enter the curriculum, providing personal counseling, and offering flexibility according to student needs, including retraining programs. Career pathways should be bolstered so that the technologist can see a "career ladder" which could lead (after appropriate education) to careers in hospital administration.

(l) A restructuring of health care givers in the hospital environment should be established, with the nursing professionals having greater autonomy [to act independently] in an administrative and clinical sense, and cooperating with physicians in establishing parameters to supervise the delivery of patient care rendered by licensed practical nurses and certified nursing aides.

(Words in brackets deleted by the Board)

(m) Recruitment of nurses from other countries should be considered.

(n) Publicity campaigns should be carried on by the appropriate professional organizations in cooperation with various technological societies, county medical societies, and specialty groups, to interest high school juniors and seniors in allied health careers.

(o) Hospitals should be encouraged through grants and budgets to open schools of technology in multiple fields. Funds should be sought to encourage hospitals in underprivileged areas to offer high school graduates opportunities to enter allied health professions for a reasonable (or minimal) tuition, and *in their local communities*. In return for volunteering to put in a certain number of years working at a hospital, hospitals should be encouraged to pay tuition for further education.

(p) Courses in interpersonal relationships and stress management should be made available and encouraged through the offices of appropriate professional organizations.

(2) Nursing Models Incentive Reimbursement Program . . .

Noted the program overview by Mrs. Mary Ann Yeager, special assistant to the deputy commissioner of health, endorsed by the Hospital Rate-Setting Commission; MSNJ will have a representative on the evaluating panel; and approved the following:

That the Medical Society of New Jersey support the Nursing Models Incentive Reimbursement Program.

That New Jersey hospitals be notified of the Society's support of the program.

Meeting with Senator Bill Bradley . . . Noted meeting with the senator to discuss expenditure targets and the Rockefeller/Durenberger reform package that gives authority to Health and Human Services Secretary and the Office of Management and Budget to set up a default conversion factor update for Medicare services should Congress fail to act.

JEMPAC . . . Noted the following: treasurer's report showed \$130,115.96 in funds; meeting with James J. Florio; legislative questionnaire sent to Assembly candidates; and commendation to Auxiliary for promoting physician voter registration.

Medicare Reimbursement . . . Accepted Pennsylvania Blue Shield's discussion on the request for their review policy that is consistent with current Medicare program requirements.

Conference Date . . . Noted that on November 18, the Hospital Medical Staff section is sponsoring a program on the deferred reimbursement policy for physicians.

UMDNJ NOTES

Ruy V. Lourenco, MD, an internationally respected medical educator, researcher, and clinician, has been named the new dean of UMDNJ-New Jersey Medical School. He will join the Newark-based medical school in March, succeeding Stuart D. Cook, MD, professor and chairman of neurosciences, who has been serving as acting dean. Dr. Lourenco will join UMDNJ following a 22-year career with the University of Illinois College of Medicine. For the past 12 years, he has been chairman of the Department of

Medicine and Foley professor of medicine at the medical college professor of physiology at the Graduate College of the University of Illinois, and physician-in-charge of University of Illinois Hospital. As a clinician and scientist, Dr. Lourenco is among the nation's leading experts in pulmonary and respiratory diseases. He has lectured on this specialty worldwide and his research has generated nearly 200 scientific articles, abstracts and other publications.

I also must commend the efforts of Dr. Cook, who served in the acting post since 1987. He did a superior job of leading both the medical school and his Department of Neurosciences.

Another important appointment at UMDNJ-New Jersey Medical School is that of Stephen A. Udem, MD, PhD, as director of the Division of Infectious Disease.

A noted researcher and clinician and an authority on the measles virus, Dr. Udem is director of the infectious disease divisions at the medical school, where he has been appointed professor of medicine and at UMDNJ-University Hospital. Dr. Udem comes to UMDNJ from Albert Einstein College of Medicine in the Bronx, New York, where he held appointments in the Department of Medicine and the Department of Microbiology and Immunology. He was a graduate of the medical college's first joint MD/PhD program, receiving a doctorate in genetics and cell biology in 1971 and a medical degree the following year.

Dr. Udem's scientific focus has centered on viruses that persist in the human body—those that can be in the system for years before surfacing as disease. Two of his primary targets are the viruses that cause measles and AIDS.

A \$127,000 federal grant will be used to expand the clinical service and research efforts of the Center for Children's Support at UMDNJ-School of Osteopathic Medicine, in Stratford. The grant

is provided under the federal Children's Justice Act and administered by the New Jersey Division of Youth and Family Services (DYFS). It will permit the center to expand its diagnostic services, provide continuity of care, and provide training and consultation for medical practitioners, mental health professionals, and community agencies.

The Center is directed by Dr. Martin Finkel, acting chairman of pediatrics at the osteopathic medical school and a nationally recognized expert on the medical evaluation of sexually abused children.

The Environmental and Occupational Safety and Health Education and Training Center (EOSHETC), part of UMDNJ-Robert Wood Johnson Medical School, opened a new headquarters at Brookwood Plaza II, 45 Knightsbridge Road, Piscataway.

The 6,000-square-foot Center brings together these major continuing education and training programs:

- The New Jersey/New York Hazardous Materials Worker Training Center that provides comprehensive health and safety training to a wide variety of workers potentially exposed to dangerous substances.

- The Universities Occupational Safety and Health Educational Resource Center, sponsored by the National Institute for Occupational Safety and Health (NIOSH) and part of a nationwide network, is a consortium of five universities in New Jersey and New York. This center trains occupational safety and health professionals—occupational physicians, nurses, industrial hygienists and others in related disciplines.

- The Mid-Atlantic Asbestos Training Center, established by the federal Environmental Protection Agency (EPA) as a satellite training center, operates programs on asbestos and asbestos-related topics that fulfill EPA and other federal agency training require-

ments for New Jersey, New York City, and New York State. □ Stanley S. Bergen, Jr, MD

■ MSNJ AUXILIARY ■

The Auxiliary has launched a major membership drive. Sevim Omay, MSNJA president, has sent letters to all New Jersey physicians encouraging them to support their spouses' involvement in the "one and only organization that works exclusively for medicine and the medical family." Mrs. Omay points out that because the medical profession is going through so many changes, the Auxiliary's priorities are changing and increasing, and its role in the world of medicine is more significant than ever. Auxiliary members, as the physicians' confidantes and greatest advocates, potentially are their most articulate and enthusiastic spokesmen. They willingly contact legislators and vigorously lobby for the introduction of sound medical legislation and the defeat of undesirable bills. They strive to enhance the image of medicine in the community by organizing successful fundraisers for health career scholarships, and by sponsoring medical education programs.

Nationwide, the Auxiliary's greatest accomplishment is its fundraising for AMA-ERF (American Medical Association and Research Foundation). In an effort to maintain quality medical education and assist research in the nation's medical schools, the AMA Auxiliary has made AMA-ERF its sole, national philanthropic endeavor. Tax-deductible contributions to AMA-ERF (for example, through the Auxiliary's "Holiday Sharing Card") can be designated to benefit the medical school of choice. Funds are allocated to the Medical School Excellence Fund or to the Medical Student Assistance Fund.

Of course, there are many other reasons to become a member of this great organization. The fall issue of the Auxiliary's official

publication, *The Shingle*, showcases the activities and plans that only a growing and vital membership can accomplish: legislative actions, county programs, achievements of individual members and their beautiful children, health issues, and a feature on anabolic steroids. □ Marion H. Geib

■ SBME UPDATE ■

As the newly elected president of the New Jersey State Board of Medical Examiners, I am proud to follow in the footsteps of former presidents, Drs. Edwin Albano, Edward Luka, and Frank Malta. All three former Board presidents were proud and active members of the Medical Society of New Jersey. I serve as the first Board president who is not a member of the Medical Society. This fact provides me with a unique advantage.

This advantage is the ability to objectively redefine the relationship between the State Board of Medical Examiners and the Medical Society of New Jersey. For too long, these two agencies have progressed on parallel tracks with interactions being somewhat infrequent. The only exception to this, of course, has been the cooperation between the State Board and the Physicians' Health Program. Certainly, there are issues of mutual concern to both agencies; I plan to work hard to identify these issues. Once identified, it will be imperative for our organizations to work together to constructively review the issues and ameliorate the definable problems.

However, there will continue to be some areas where there is a divergence of opinion. I suggest that we simply agree to disagree in those areas; but, by and large, even though we may serve different constituencies, we both have the same goal—the best possible quality of health care for the citizens of New Jersey.

One area of concern that should be of increasing importance to us all is the dramatic increase in the

number of complaints that come to the Board. In 1987, we received approximately 365 complaints. In 1988, the number jumped to over 500 complaints. It is expected that at the current rate in 1989, the number of complaints will exceed 600. We can only guess that the increasing number of complaints reflects many factors: increasing consumer demand for quality health care, our increasingly litigious society, and the public's increased awareness of the presence of the Board.

With this dramatic expansion in caseload, the Board recognized the need to increase the number of Board office personnel. The State hiring freeze imposed in winter 1988 impeded the Board office expansion effort. Fortunately, the Board office now is able to increase its staff. Additional personnel already have been hired, and we are hoping to deal with the complaints in a prompt and efficient manner.

Increasingly, we need the services of experts in many medical fields. It is my plan to work together with the Medical Society and with the specialty components societies in an attempt to identify a large pool of recognized experts who would be willing to volunteer opinions regarding complaints made by the consumers of medical care. The information that the experts would be asked to review would be purged of all names and addresses of both the consumers and the practitioners. This initial review would simply indicate to us whether there was an issue on which the Board had authority to intervene. More than half of the consumer complaints coming into the office are found, after initial review, not to involve any violations of the Medical Practice Act. Board action on these cases stops immediately, and all parties are notified that there is no cause for action. Prompt handling of these nonviolation complaints certainly will be a very valuable service; a service not only to the consumers

but to the physicians and other licensees involved.

The cooperative effort between the State Board of Medical Examiners and the Physicians' Health Program has been mentioned. It certainly is my intention, during my term, to continue that cooperation. I also plan to more formally define the lines along which both agencies operate. At the same time, I plan to continue the Board's very tough stance of taking strong actions against doctors who are dispensing drugs for profit. That always has been the position of this Board, and, in this era of increased awareness of the drug epidemic, dishonest physicians will not be tolerated. While crack and cocaine obviously are not coming from physicians' offices, the third most frequently abused drug in many metropolitan areas is the combination known as "hits"—Doriden® and codeine-containing preparations. These substances are being obtained mainly from physicians' prescriptions. It is becoming increasingly difficult to believe that physicians can be unaware of the illicit use of that strange therapeutic combination.

Two issues of interest to the Medical Society are the problem of physicians who are HIV positive and the issue of physician assistants. I have assembled task forces on both of these matters and have solicited input from the Medical Society as well as from a number of other groups who have some expertise in these areas. Decisions made by the Board in large measure, will be based upon the collection of facts and the recognition of the opinions that are collected by the task forces. I personally am chairing the task force on the HIV positive physicians; Dr. Fred Jacobs is chairing the task force on physician assistants.

Last and certainly not least is the recognition of the need for a full-time medical director to be employed by the Board. It is important for the Board staff to have

the input of a physician on a daily basis, and this can only be accomplished by the presence of a medical director. For the past two months, we have been involved in a search to fill that position and expect in the near future to name an individual to the post. The Board was gratified to receive a large number of applications, and the applicants included many very well-qualified individuals.

As I begin my term as president of the Board of Medical Examiners, I am optimistic that I will be able to continue to work toward the goals established by my predecessors. I am determined to re-establish an appropriate working relationship with the Medical Society in order to better serve the health needs of the citizens of the state of New Jersey. □ Michael Grossman, DO

Editor's note: We welcome Dr. Michael Grossman as the new president of the State Board of Medical Examiners, and are pleased to have this column for *NEW JERSEY MEDICINE*. We look forward to continued input from SBME on issues affecting the medical profession in New Jersey.

NEW MEMBERS

The Medical Society of New Jersey would like to welcome the following new members:

Atlantic County

Joseph J. Caldwell, MD
Brian K. Kirchner, MD
Rose A. Metzger, MD
Richard A. Mingione, MD
Hareshbhai C. Patel, MD

Bergen County

Morris Bellifemine, MD
Harry Katz, MD
Rajeev S. Motiwala, MD
Arthur C. Rothman, MD
Jason B. Surow, MD

Burlington County

Stanley R. Askin, MD
Steven B. Kirshner, MD
Lynn B. McGrath, MD

Camden County

Ronald A. Cohen, DO
Mitchell C. Rosenberg, MD
Robert J. Segal, MD

Camden County

Lawrence J. Chase, MD

Essex County

Susan V. Berger, MD
Harry A. Halejian, MD
Iva M. Horn, MD
Mark A. Lister, MD
Michael Scoppetuolo, MD

Hampden County

Fitchell N. Kotler, MD

Hudson County

George L. Vereia, MD

Mercer County

Kenneth M. Given, MD
Alan E. Ottenstein, MD
Stephen B. Presant, MD
Harry R. Rossman, MD

Middlesex County

Michel M. Amzallag, MD
Bibhay Bhatnagar, MD
Timothy H. Bulkley, MD
Glenn A. Dubov, MD
Nicholas Ferrentino, MD
Elliot M. Heller, MD
Joseph R. Ivan, MD
Parayanan Jeganathan, MD
Peter S. Johnston, MD

Joseph Terrazzino, MD
Windsor Ting, MD

Monmouth County

Richard A. Chazkel, MD
Maria Choy-Kwong, MD
Frederick A. DePaola, MD
Jeffrey W. France, DO
James M. Fusaro, MD
Michael F. Lospinuso, MD
David G. Paris, MD
Shashikant A. Patel, MD
Harlayne C. Roberts, DO
Howard P. Rosenstein, MD
John M. Tozzi, MD

Morris County

John J. Castronuovo, Jr, MD

Ocean County

Omar F. Almallah, MD
Frank J. Catalfumo, MD
Morris Feitel, MD
Earl F. Jackman, DO
David P. Morrison, Jr, MD
Kiritkumar M. Pandya, MD

Passaic County

Behzad Ahkami, MD
Carla M. Grosmann, MD
Mark Teicher, MD
Eugene Wallsh, MD

Somerset County

Melodee S. Lasky, MD
James A. Neubrandner, MD

Union County

Antonio S. Dyogi, MD

Richard R. Eisenberg, MD
Alok Goyal, MD
Gary S. Herring, MD
Willy Hoffmeister, MD
Godson G. Kotia, MD
Alan R. Plauka, MD
Sharon E. Selinger, MD

PLACEMENT FILE

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY

Hak Joo Cha, MD, 22 Hamilton Ct., Lawrenceville, NJ 08648. Catholic Medical College 1972. Board eligible. Solo, partnership, group, fee-for-service. Available.

CARDIOLOGY

Fredric Gerewitz, MD, 125 Montgomery Ave., Bala Cynwyd, PA 19004. SUNY-Downstate 1984. Board eligible. Group or partnership. Available July 1990.

Matilda M. Taddeo, MD, 2269 Ellis Ave., Bronx, NY 10462. West Indies 1983. Board eligible. Group or partnership. Available.

GASTROENTEROLOGY

David L. Fishkin, MD, 1000J Scaife Hall, University of Pittsburgh, Pittsburgh, PA 15261. SUNY-Downstate 1985. Board eligible. Board certified (IM). Group, partnership, solo. Available July 1990.

INTERNAL MEDICINE

Michael G. Donnelly, MD, 10 Overlook Rd., Apt. 4H, Summit, NJ 07901. Medical College of Pennsylvania 1987. Board eligible. Group or partnership. Available.

ORTHOPEDICS

D.C. Brown, MD, 2319 Sayre Dr., Princeton, NJ 08540. Available.

OTOLARYNGOLOGY

Samuel H. Selesnick, MD, 450 East 63rd St., #8F, New York, NY 10021. NYU 1985. Board eligible. Available July 1990.

Continuing Medical Education in New Jersey

\$5.00

September 1989

Send check to: **NEW JERSEY MEDICINE**
Two Princess Road
Lawrenceville, NJ 08648
609/896-1766

STATEMENT OF OWNERSHIP, MANAGEMENT, AND CIRCULATION

(Required by 39 U.S.C. 3685)

1. Title of Publication: NEW JERSEY MEDICINE.

1A. Publication No.: 00257524.

2. Date of Filing: September 26, 1989.

3. Frequency of Issue: Monthly.

3A. No. of Issues Published Annually: 12.

3B. Annual Subscription Price: \$35.00.

4. Location of Known Office of Publication: 2 Princess Road, Lawrenceville, Mercer County, NJ 08648.

5. Location of Headquarters or General Business Office of the Publisher: 2 Princess Road, Lawrenceville, Mercer County, NJ 08648.

6. Names and addresses of publisher, editor, and managing editor: Publisher, Medical Society of New Jersey, 2 Princess Road, Lawrenceville, NJ 08648. Editor, Howard D. Slobodien, MD, 2 Princess Road, Lawrenceville, NJ 08648. Managing Editor, Geraldine R. Hutner, 2 Princess Road, Lawrenceville, NJ 08648.

7. Owner (if owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.): Medical Society of New Jersey, 2 Princess Road, Lawrenceville, NJ 08648 (a nonprofit corporation of New Jersey).

8. Known bondholders, mortgages, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages, or other securities: None (a nonprofit corporation of New Jersey).

9. For completion by nonprofit organization authorized to mail at special rates (Section 411.3, DMM only). The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes have not changed during preceding 12 months.

10. Extent and nature of circulation:

Extent and nature of circulation	Average no. copies each issue during preceding 12 months	Actual no. copies of single issue published nearest to filing date
A. Total no. copies printed (net press run)	10,802	10,576
B. Paid circulation		
1. Sales through dealers and carriers, street vendors, and counter sales	—	—
2. Mail subscriptions	9,993	9,767
C. Total paid circulation (sum of B1 and B2)	9,993	9,767
D. Free distribution by mail carrier or other means—samples, complimentary, and other free copies	589	589
E. Total distribution (sum of C and D)	10,582	10,356
F. Copies not distributed		
1. Office use, left-over, unaccounted, spoiled after printing	220	220
2. Return from new agents	—	—
G. Total (sum of E, F1, and 2—should equal net press run shown in A)	10,802	10,576

11. I certify that the statements made by me above are correct and complete.

(signed) Arthur White

Director of Finance and Administrative Services

12. For completion by publishers mailing at the regular rates (Section 132.121, Postal Service Manual), 39 U.S.C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matters at such rates." In accordance with the provisions of this statute, I hereby request permission to mail the publication named in item 1 at the phased postage paid rate presently authorized by 39 U.S.C. 3626.

EDITORIAL CRITERIA

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. All material published is copyrighted by the Medical Society of New Jersey.

Content. The educational content of each issue appears as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; and special articles, which include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include commentary (critical narration); medical history; therapeutic drug information; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational, informational, and administrative items from MSNJ and from the community. Letters to the editor and book reviews are welcome and will be published as space permits. The principal aim in the preparation of a contribution should be relevant to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made to an audience in New Jersey.

Assignment of Copyright. In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or a separate statement accompany-

ing material offered to *NEW JERSEY MEDICINE* must contain the following language and must be signed by all authors.

"In consideration of *NEW JERSEY MEDICINE* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *NEW JERSEY MEDICINE*.

Specifications. Submit two manuscripts that must be typewritten and double-spaced on 8½" by 11" paper. Statistical methods should be identified.

Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important.

The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests and correspondence should be sent.

The author should submit a 30-word abstract.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission must be submitted.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

References should not exceed 35 citations except in review articles, and should be cited consecutively by numbers in parentheses at the end of the sentence. The reference list should be typewritten and double-spaced on separate 8½" by 11" sheets in numerical order. The style of *NEW JERSEY MEDICINE* for references is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

2. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

Publication Policy. Receipt of each manuscript will be acknowledged; the paper will be referred to the Editorial Board. The final decision is reserved for the editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. Galley proofs will be submitted to the author for correction.

Reprint Orders. Reprints may be ordered after the author is notified that the article has been selected for a specific issue. A check for the cost of reprints must accompany that order.

Communications. All communications should be sent to the editor, *NEW JERSEY MEDICINE*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648.

The Academy of Medicine
of New Jersey
in cooperation with

UMDNJ—Robert Wood Johnson Medical School
& Robert Wood Johnson University Hospital

present

**AN INTENSIVE REVIEW
OF INTERNAL MEDICINE**

January 17, 1990-May 23, 1990

Wednesdays

4:00 P.M.-7:00 P.M.

at

ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL
NEW BRUNSWICK, NEW JERSEY

The course is designed to provide a comprehensive review of contemporary concepts in Internal Medicine. It is designed for practicing internists and family practitioners. The review will also be useful for residents. Syllabus material will be distributed during the course which will, when compiled, provide an extremely useful reference.

COURSE CHAIR: Robert Eisinger, M.D.

For further information on registration, faculty
and fees, please contact:



Diane Deltino
Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, New Jersey 08648
609-896-1717

**Acupuncture & Electro-Therapeutics
in Clinical Practice**

New York State Boards of Medicine & Dentistry 25-hour accredited seminar & workshop on latest theories and techniques of manual & electro-acupuncture, TENS & simple non-invasive diagnostic methods (including cardio-vascular, neuromuscular, central nervous systems & "Bi-Digital O-Ring Test"), applicable towards 300-hour requirement for certification to practice acupuncture, will be given periodically for licensed clinicians (with or without prior training) on 3-day weekends (Fri-Sun) of Dec. 8-10, 1989 & Jan. 26-28, 1990, both at Milford Plaza Hotel, 45th St. & 8th Ave., New York City.

These meetings are co-sponsored by the International College of Acupuncture & Electro-Therapeutics & its official journal, *Acupuncture & Electro-Therapeutics Research*. The *International Journal* (published by Pergamon Press & indexed in 15 major indexing periodicals, including Index Medicus), Heart Disease Res. Foundn, N Y Pain Center of Long Island College Hospital (a teaching hospital of SUNY-Health Science Center at Brooklyn); Electrical Engineering Dept., Manhattan College; Nordic Medical Acupuncture Society (Scandinavia); Schmerz Therapeutische Kolloquium (West Germany); Japan Bi-Digital O-Ring Test Assn; etc. The meetings are also eligible for AMA CME Cat. I credit (about 40 credit-hours for the Symposium).

For information on meetings or submission of papers, contact Symposium Chairman Y. Omura, M.D., Sc.D., 800 Riverside Drive (8-1) New York, NY 10032 Tel: (212) 781-6262 (10am to 10pm 7 days a week) or (212) 928-0658, Dr. Shinnick (212) 727-9674, or Bro. Michael Losco (212) 920-0162.



Deborah
Heart and Lung
Center

**CLINICAL UPDATE
PULMONARY MEDICINE**

November 29, 1989

COURSE DESCRIPTION:

The 6th Annual Clinical Update is designed to provide family practitioners, general internists, pulmonologists, and other interested physicians with an updated review of pulmonary disorders which are commonly encountered in clinical practice as well as certain disorders which are of current topical interest. The program has been carefully selected to ensure a good blend of established and new methods and approaches to pulmonary diseases.

The morning session will provide participants with systematic approaches to chest x-ray interpretation, asthma, tuberculosis and chronic obstructive pulmonary disease.

The afternoon session will present current concepts in the diagnosis and management of asbestosis, pulmonary thromboembolism, and drug-induced lung disease. A special lecture will focus on the current status of alpha₁-antitrypsin replacement therapy in hereditary emphysema.

Throughout the day, emphasis will be placed on risk factors, natural history, early detection, prognosis, newer diagnostic techniques and new methods of therapy.

A.M.

MORNING SESSION

- 8:00 Registration
- 8:50 Welcome—Vladir Maranhao, M.D.
- 9:00 A Practical Guide to Chest X-Ray Interpretation
Wallace T. Miller, M.D.
- 9:50 "Asthma: Current Concepts in Pathophysiology and Therapy"
James E. Fish, M.D.
- 10:40 Coffee Break
- 10:55 "Evaluation and Management of COPD in 1989"
David M. F. Murphy, M.D.
- 11:45 "Current Approach to Tuberculosis in the Era of HIV Infection"
Elias Abrutyn, M.D.

P.M.

AFTERNOON SESSION

- 12:30 Luncheon
- 1:30 Clara Falk Franks Lecture—"Alpha₁-Antitrypsin Deficiency: A Treatable Hereditary Disorder"
Ronald G. Crystal, M.D.
- 2:20 "Deep Vein Thrombosis and Pulmonary Embolism: Diagnosis and Pathophysiology"
Mark A. Kelley, M.D.
- 3:10 Coffee Break
- 3:25 "Asbestosis: Clinical Disorders Associated with an Inorganic Material"
Ronald G. Crystal, M.D.
- 4:15 "Drug-Induced Lung Disease"
Mervyn Feilerstein, M.D.

Tuition: All participants, fee includes luncheon and refreshments—\$90.00.

A check in the amount of \$90.00 payable to Deborah Heart and Lung Center should accompany this application. Mail to Pulmonary Department, Deborah Heart and Lung Center, Browns Mills, N.J. 08015.

Due to limited seating capacity, early registration is strongly advised. Registration deadline—Wednesday, November 15, 1989.

Accreditation: Deborah Heart and Lung Center designates that this continuing medical education offering meets the criteria for 6.5 credit hours in category 1 of the Physician's Recognition Award of the American Medical Association.

This program has been reviewed and is acceptable for 6.5 prescribed hours by the American Academy of Family Physicians.

For Program Information please call: Mrs. Diane Colby (609) 893-6611.

CONTINUING EDUCATION

ANESTHESIOLOGY

January

6 Meeting

6-9 P.M.—Ramada Inn, Clark
(*New Jersey State Society of Anesthesiologists*)

CARDIOLOGY

December

Saving Lives Post-MI

8:30 A.M.—United Hospitals
Medical Center, Newark
(*United Hospitals Medical Center*)

January

1 Atherosclerosis

11 A.M.-12 Noon—St. Joseph's
Hospital and Medical Center,
Paterson
(*St. Joseph's Hospital and Medical Center*)

2 Nuclear Cardiology

1-2 P.M.—North Princeton
Developmental Center, Princeton
(*AMNJ*)

DERMATOLOGY

January

1 Common Dermatoses

1:30-2:30 P.M.—Vineland
Developmental Center, Vineland
(*AMNJ*)

7 Robert Wood Johnson Medical School Dermatological Conferences

6-9 P.M.—Rutgers Community
Health Plan, US #1,
New Brunswick
(*UMDNJ*)

INFECTIOUS DISEASE

January

Clinical Management of HIV Infection

12 Noon-1 P.M.—The Hospital
Center at Orange, Orange
(*AMNJ*)

MEDICINE

December

Lecture Series

8 8:30-10 A.M.—United Hospitals
15 Medical Center, Newark
(*United Hospitals Medical Center*)

1 Continuing Medical Education

8 12 Noon-1 P.M.—South Jersey
15 Hospital System, Bridgeton
22 (*South Jersey Hospital System*)
29

1 Treatment of Inflammatory Bowel Disease

12 Noon-1 P.M.—South Jersey
Hospital System, Bridgeton
(*South Jersey Hospital System*)

1 Diabetes in Pregnancy

12 Noon-1 P.M.—South Jersey
Hospital System, Bridgeton
(*AMNJ*)

4 Seminars for Physicians and Dentists

All day—Ancora Psychiatric
Hospital, Hammonton
(*AMNJ*)

5 Medical Literature Search Using Grateful Med Search

9 A.M.-1 P.M.—UMDNJ,
Stratford
(*UMDNJ*)

5 Diabetic Retinopathy

2-3 P.M.—Hunterdon
Developmental Center, Clinton
(*AMNJ*)

5 Strokes

10-11 A.M.—Green Brook
Regional Center, Green Brook
(*AMNJ*)

5 Electrolyte Imbalance and Management

11 A.M.-12 Noon—West Hudson
Hospital, Kearny
(*West Hudson Hospital*)

6 Continuing Medical Education Series

1:30-2:30 P.M.—Rutgers
Community Health Plan,
New Brunswick
(*Rutgers Community Health Plan*)

6 Autologous Blood Transfusion

10:30-11:30 A.M.—St. Mary's
Hospital, Passaic
(*AMNJ*)

6 Medical Lecture Series

13 10:30-11:30 A.M.—Christ

20 Hospital, Jersey City
27 (*Christ Hospital*)

7 GI Advances in Peptic Ulcer Disease

11 A.M.-12 Noon—St. Joseph's
Hospital and Medical Center,
Paterson
(*AMNJ*)

7 Continuing Medical Education Series

12 Noon—Somerset Medical
Center, Somerville
(*Somerset Medical Center*)

12 Renal Biopsy Conference

12:30-2 P.M.—Barnert Memorial
Hospital Center, Paterson
(*Barnert Memorial Hospital Center*)

13 Difficult Decisions in Medicine: Code Status

7:30 P.M.—Englewood Hospital
(*Englewood Hospital*)

13 Nephropathy

12 Noon-1 P.M.—St. James
Hospital, Newark
(*AMNJ*)

13 Proper Use of IV Sedation

8-9 P.M.—West Jersey Hospital,
Camden
(*AMNJ*)

13 Orthotics and Prosthetics in the 1990s

12 Noon-1 P.M.—St. Lawrence
Rehabilitation Center,
Lawrenceville
(*St. Lawrence Rehabilitation Center*)

15 Viruses and Hematopoiesis

8:30-10 A.M.—United Hospitals
Medical Center, Newark
(*United Hospitals Medical Center*)

19 Seizures

1:30-3 P.M.—Marlboro
Psychiatric Hospital, Marlboro
(*AMNJ*)

19 Medical Grand Rounds

9-10 A.M.—Holy Name Hospital,
Teaneck
(*Holy Name Hospital*)

23 Morbidity and Mortality

30 Conference

8:30-10 A.M.—UMDNJ, Newark
(*UMDNJ*)

PHILADELPHIA HEART INSTITUTE
of Presbyterian Medical Center

Cardiology Update

*designed for the physician and provides an intensive
survey of the current status of clinical cardiology. . .*

Wednesday, December 6, 1989 3:00-5:00 PM

Syncope: Cardiac or Non-Cardiac Etiology

Moderator

Leonard N. Horowitz, M.D.

3:00-3:30	Cardiac syncope: diagnosis and management	<i>Leonard N. Horowitz, M.D.</i>
3:30-4:00	Non-cardiac syncope	<i>Mildred La Fontaine, M.D.</i>
4:00-5:00	Case presentations—The symptom of syncope in the cardiac patient	<i>David L. Scher, M.D.</i>
	Panel discussion	
	<i>Norman Feinsmith, M.D.</i>	<i>Ancil A. Jones, M.D.</i>
	<i>Steven J. Nierenberg, M.D.</i>	<i>William J. Untereker, M.D.</i>

- Case Presentations and Panel Discussions
- CME Credits*
- No Registration Fee
- Call for Reservation 215-662-8627

Scheie Auditorium
Presbyterian Medical Center
39th & Market Streets
Philadelphia, Pennsylvania 19104

*The Philadelphia Heart Institute at Presbyterian Medical Center is an affiliate of the University of Pennsylvania. "The University of Pennsylvania School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The University of Pennsylvania School of Medicine designates this Continuing Medical Education activity for 2 credit hours per session in Category 1 of the Physician's Recognition Award of the American Medical Association."

- 20 **Nephrotoxicity of Common Drugs**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)
- 20 **Periodic Health Screening**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)
- 21 **Diabetes in Pregnancy**
8:30-9:30 A.M.—Dover General Hospital, Dover
(AMNJ)
- 21- **Sinus Endoscopy**
22 7:30 A.M.-4 P.M.—New Jersey Medical School, Newark
(UMDNJ)
- January**
- 3 **Medical Lecture Series**
10 10:30-11:30 A.M.—Christ Hospital, Jersey City
17 (Christ Hospital)
24
31

- 5 **Continuing Medical Education Series**
- 12 12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(South Jersey Hospital System)
- 26 **Renal Biopsy Conference**
12:30-2 P.M.—Barnert Memorial Hospital Center, Paterson
(Barnert Memorial Hospital Center)
- 9 **Prevention of Lower Extremity Amputations**
9-10 A.M.—Somerset Medical Center, Somerville
(AMNJ)
- 12 **Food and Drug Interactions**
10:30-11:30 A.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)
- 16 **Host Defense Mechanisms of the Peritoneal Cavity and CAPD Peritonitis**
6:30-9:30 P.M.—Overlook Hospital, Overlook
(AMNJ)
- 17 **Laser Treatment of Massive GI Hemorrhage and GI Carcinomas**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)
- 17 **Diabetes-Related Kidney Disease**
9-10 A.M.—Somerset Medical Center, Somerville
(AMNJ)
- 17 **Geriatric Patient and Alzheimer's Disease**
11 A.M.-12 Noon—West Hudson Hospital, Kearny
(West Hudson Hospital)
- 17 **Internal Medicine Review Course**
4-7 P.M.—University Hospital, New Brunswick
(AMNJ and UMDNJ)
- 17 **Common Uses in OP Treatment**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)
- 18 **Continuing Medical Education Series**
12 Noon—Somerset Medical Center, Somerville
(Somerset Medical Center)
- 19 **Limb Salvage in Diabetes**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(South Jersey Hospital System)
- 20 **Morbidity and Mortality Conference**
27 8:30-10 A.M.—New Jersey Medical School, Newark
(UMDNJ)

1990 MSNJ ANNUAL MEETING

Saturday, May 5, 1990

- 3:30 p.m. **Board of Trustees' Meeting**
7:00 p.m. **Officers' Cocktail Reception and Dinner**

Sunday, May 6, 1990

- 8:00 a.m. **Registration Opens**
8:00 a.m. **Message Center Opens**
10:00 a.m. **Educational Program**
11:00 a.m. **Exhibits Open**
1:00 p.m. **House of Delegates**
3:30 p.m. **Reference Committee Meetings**

Monday, May 7, 1990

- 8:00 a.m. **Registration Opens**
8:00 a.m. **Message Center Opens**
8:30 a.m. **Exhibits Open**
9:00 a.m. **House of Delegates (Election)**
12:00 noon **Golden Merit Award Ceremony and Reception**
1:00 p.m. **Professional Liability Program (MIENJ)**
2:45 p.m. **Reference Committee Meetings**
5:00 p.m. **JEMPAC Political Forum**
5:45 p.m. **JEMPAC Wine and Cheese Reception**
6:30 p.m. **Somerset County Medical Society**

Tuesday, May 8, 1990

- 8:00 a.m. **Registration Opens**
8:00 a.m. **Message Center Opens**
8:30 a.m. **Exhibits Open**
9:00 a.m. **House of Delegates**
1:30 p.m. **House of Delegates**
2:00 p.m. **Exhibits Close**
6:30 p.m. **Inaugural Reception and Dinner**

Wednesday, May 9, 1990

- 8:00 a.m. **Registration Opens**
8:00 a.m. **Message Center Opens**
8:30 a.m. **General Session**
1:00 p.m. **Board of Trustees' Meeting**



Hahnemann University
DEPARTMENT OF MEDICINE

GRAND ROUNDS

December 6, 1989

INSULIN RESISTANCE IN HYPERTENSION

Michael Tuck, M.D.
University of California
at Los Angeles

December 13, 1989

REFLUX ESOPHAGITIS: NEWER TREATMENT

Richard McCallum, M.D.
University of Virginia

December 20, 1989

PHOTOPHORESIS FOR CUTANEOUS DISEASE

Eric Vonderheid, M.D.
Hahnemann University

Medical Seminar Series

December 6, 1989: HYPERTENSION—Insulin, Mineralocorticoid, Geriatric

P.M.

1:00 —Geriatric Hypertension
Michael Tuck, M.D.

1:40 —Renal Artery Stenosis in the Elderly
Allan B. Schwartz, M.D.

2:10 —Systolic Hypertension
Arthur R. Olshan, M.D., Ph.D.

2:30 —Clinical Pharmacology: Rules for the Elderly
Stephen R. Porter, Pharm.D.

3:00 —Panel Discussion

December 12, 1989: GASTROESOPHAGEAL MOTILITY & ACIDITY DISORDERS

P.M.

1:00 —C. pylori
Richard McCallum, M.D.

1:45 —H₂ Blocker Therapy for Peptic Ulcer Disease
Harris R. Clearfield, M.D.

2:15 —Alcoholic Gastritis
Vincente P. Dinoso, M.D.

3:00 —Questions and Answers

Presented by:

William S. Frankl, MD

Professor of Medicine and Chairman
Department of Medicine

Allan B. Schwartz, MD

Professor of Medicine
Director, Continuing Medical Education
Department of Medicine

We wish to acknowledge educational grant support from:

Classroom C (Alumni Hall)
2nd Floor New College Bldg.
Hahnemann University
15th Street Entrance
15th & Vine Streets
Philadelphia, PA

Burroughs Wellcome Co.
E. R. Squibb & Sons
GLAXO
Merck Sharp & Dohme
Ortho Pharmaceutical Corp.
Sandoz Pharmaceuticals
Searle & Co.

Approved for CME credits through the Office of Continuing Education, Hahnemann University

FOR FURTHER INFORMATION—(215) 448-8263

- 23 Dually Diagnosed**
2:30-3:30 P.M.—New Lisbon
Developmental Center,
New Lisbon
(AMNJ)
- 24 Diabetes in Pregnancy**
9-10 A.M.—Somerset Medical
Center, Somerville
(AMNJ)
- 24 Retinopathy**
12 Noon-1 P.M.—St. James
Hospital, Newark
(AMNJ)
- 25 Visiting Professor Program**
1:30-5 P.M.—Saint Barnabas
Medical Center, Livingston
(Saint Barnabas Medical Center)
- 26 Update in Ophthalmology**
12 Noon-1 P.M.—South Jersey
Hospital System, Bridgeton
(South Jersey Hospital System)
- 31 Retinopathy**
9-10 A.M.—Somerset Medical
Center, Somerset
(AMNJ)

OBSTETRICS AND GYNECOLOGY

December

- 8 Menopause and Estrogen
Replacement Therapy**
12 Noon-1 P.M.—South Jersey
Hospital System, Bridgeton
(South Jersey Hospital System)
- 12- Third Annual Practical**
- 14 Approaches to the Ob/Gyn
Specialties**
7 A.M.-1 P.M.—Condado Plaza
Hotel, San Juan, Puerto Rico
(UMDNJ)

ONCOLOGY

December

- 6 Annual Clinical Abstract
Meeting**
1:30-5 P.M.—The Manor,
West Orange
(Oncology Society of New Jersey)
- 8 Tumor Board Meeting**
11 A.M.-12 Noon—Wallkill Valley
Hospital Center, Sussex
(Wallkill Valley Hospital Center)
- 14 Dinner Meeting**
6:30-9:30 P.M.—The Hyatt,
New Brunswick
(AMNJ—Head and Neck
Oncology Section)
- 28 Tumor Board Conference**
12 Noon-1 P.M.—Newcomb
Medical Center, Vineland
(Newcomb Medical Center)

January

- 10 Tumor Board Conference**
12 Noon-1 P.M.—Memorial
Hospital of Salem County, Salem

(Memorial Hospital of Salem
County)

- 12 Tumor Board Meeting**
11 A.M.-12 Noon—Wallkill Valley
Hospital Center, Sussex
(Wallkill Valley Hospital Center)
- 25 Tumor Board Conference**
12 Noon-1 P.M.—Newcomb
Medical Center, Vineland
(Newcomb Medical Center)

PEDIATRICS

January

- 3 Child Abuse—Neglect**
10:30-11:30 A.M.—St. Mary's
Hospital, Passaic
(AMNJ)
- 4 Pediatric Grand Rounds**
- 11 8:30-9:30 A.M.—Robert Wood**
- 18 Johnson Medical School, MEB,**
- 25 102, New Brunswick**
(UMDNJ)
- 18 Update in Aspects of Pediatrics**
Marriott Hotel, Saddle Brook
(Northern NJ Pediatric Society)

PSYCHIATRY

December

- 7 Psychotherapy with Children
and Adolescents**
12 Noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)
- 7 Psychiatry and the Law**
1:30-2:30 P.M.—Essex County
Hospital Center, Cedar Grove
(AMNJ)
- 7 Case Seminars To Improve**
- 21 Psychotherapeutic Technique**
8-10 P.M.—2 West Northfield
Road, Livingston
(Advanced Psychiatric Study
Group)
- 13 Anxiety Disorders**
11 A.M.-12 Noon—Woodbridge
Developmental Center,
Woodbridge
(AMNJ)
- 14 Voluntary Self-Help Groups**
12 Noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)
- 21 Psychopathology in Dually
Diagnosed Adolescents**
12 Noon-1 P.M.—Carrier
Foundation, Belle Mead
(Carrier Foundation)

January

- 4 Case Seminars To Improve**
- 18 Psychotherapeutic Technique**
8-10 P.M.—2 West Northfield
Road, Livingston
(Advanced Psychiatric Group)

- 5 Addictions**
12 Noon-1 P.M.—South Jersey
Hospital System, Bridgeton
(South Jersey Hospital System)
- 10 Teenage Suicide**
10:30-11:30 A.M.—St. Mary's
Hospital, Passaic
(AMNJ)
- 11 Teenage Suicide**
1:30-2:30 P.M.—Essex County
Hospital Center, Cedar Grove
(AMNJ)

PULMONOLOGY

December

- 15 Occupational Lung Disorders**
12 Noon-1 P.M.—South Jersey
Hospital System, Bridgeton
(South Jersey Hospital System)

RADIOLOGY

December

- 21 1989 Scientific Meeting**
7:30-9:30 P.M.—Saint Barnabas
Medical Center, Livingston
(Radiological Society of
New Jersey-Diagnostic Section,
AMNJ)
- 28 Visiting Professor Program**
1:30-5 P.M.—Saint Barnabas
Medical Center, Livingston
(Saint Barnabas Medical Center)

January

- 11 Scientific Meeting**
7:30-9:30 P.M.—Overlook
Hospital, Summit
(New Jersey Institute for
Ultrasound in Medicine)
- 18 1990 Scientific Meeting**
7:30-9:30 P.M.—Saint Barnabas
Medical Center, Livingston
(Radiological Society of
New Jersey-Diagnostic Section,
AMNJ)
- 25 Visiting Professor Program**
1:30-5 P.M.—Saint Barnabas
Medical Center, Livingston
(Saint Barnabas Medical Center)

SURGERY AND ITS SPECIALTIES

December

- 2 38th Annual Meeting**
8:30 A.M.-4:30 P.M.—Sheraton
Tara, Parsippany
(New Jersey Chapter, American
College of Surgeons)
- 2 Surgery of the Great Vessels**
9-10:30 A.M.—St. Joseph's
Hospital and Medical Center,
Paterson
(St. Joseph's Hospital and
Medical Center)
- 3 Surgical Treatment of**

IINTERNATIONAL CONFERENCES™

1990 CME CRUISE/CONFERENCES ON MEDICOLEGAL ISSUES AND SELECTED MEDICAL TOPICS— Caribbean, Bermuda, Alaska/Canada, New England, Scandinavia, W. Mediterranean, Europe, Asia, Trans Panama Canal. Approved for 20-28 CME Category 1 Credits (AMA/PRA) and AAFP prescribed credits. Distinguished lecturers. Excellent group fares on finest ships. Pre-scheduled in compliance with IRS requirements. **Information: International Conferences, 1290 Weston Road, Suite 316, Ft. Lauderdale, FL 33326. (800) 521-0076 or (305) 384-6656.**

NOW AVAILABLE

Preprinted HCFA-1500 (I-84) Forms
Government Printing Office Approved

Order from

THE COLLINGSWOOD PRINTERY

632 Haddon Avenue
Collingswood, NJ 08108
(609) 854-8446

Are you spending more than

\$200/year

on Medical Waste Removal?

If you are a small generator

CALL

1-800-447-0026

Doctors Disposal Service Inc.,

*Licensed by the State of NJ,
is accepting new accounts*

Your patient need not be a Senior Citizen !

*Many UNDER 65 have a venous or arterial disorder.
For a SAFE, NON-INVASIVE and RELIABLE evaluation, information
or to make any appointments, call:*

**VASCULAR
DIAGNOSTIC
CENTER**



230 SHERMAN AVENUE • GLEN RIDGE, NEW JERSEY • 07028

(201) 748-5990

Physician consultation available

Cardiothoracic Disease
6:30-9:30 P.M.—New Jersey
Medical School, MSB, 506B,
Newark
(UMDNJ)

Weekly Vascular Case

Conference

7:30-8:30 A.M.—Robert Wood
Johnson Medical School, MEB,
108B, New Brunswick
(UMDNJ)

**Surgical Treatment of
Cardiothoracic Disease**

10-11:30 A.M.—New Jersey
Medical School, MSB, 506B,
Newark
(UMDNJ)

**Surgical Management of Peptic
Ulcer Disease**

11:30 A.M.-12:30 P.M.—United
Hospitals Medical Center,
Newark
(AMNJ)

**Morbidity and Mortality
Conference**

8:30-10 A.M.—New Jersey
Medical School, MSB, 506B,
Newark
(UMDNJ)

Journal Club
6:30-9:30 P.M.—2 Mountain
Ridge Drive, Livingston
(UMDNJ)

January

Weekly Vascular Case

Conference

7:30-8:30 A.M.—Robert Wood
Johnson Medical School, MEB,
108B, New Brunswick
(UMDNJ)

**Surgical Treatment of
Cardiothoracic Disease**

10-11:30 A.M.—New Jersey
Medical School, MSB, 506B,
Newark
(UMDNJ)

Morbidity and Mortality

Conference

8:30-10 A.M.—New Jersey
Medical School, MSB, 506B,
Newark
(UMDNJ)

**Englewood Surgical Society
Lecture Series**

8-10 P.M.—The Englewood Club,
Englewood
(Englewood Surgical Society)

**Journal Club, Section of
Cardiothoracic Surgery**
6:30-9:30 P.M.—2 Mountain
Ridge Drive, Livingston
(UMDNJ)

UROLOGY

December

Urology Grand Rounds

New Jersey Medical School,
MSB, C600, Newark
(UMDNJ)

**Extracorporeal Shockwave
Lithotripsy**

10:30-11:30 A.M.—St. Mary's
Hospital, Passaic
(AMNJ)

January

Urology Grand Rounds

New Jersey Medical School,
MSB, C600, Newark
(UMDNJ)

Winter Meeting

6:30 P.M.—Holiday Inn,
Jamesburg
(Urology Society of New Jersey)

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Category: (Please check one)

☐ Member, MSNJ

☐ Subscriber, NJ Medicine

☐ Other _____

County _____

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____

IN MEMORIAM

Lewis F. Baum. Word has been received of the death of Lewis F. Baum, MD, a retired member of our Essex County component. Dr. Baum died on August 12, 1989, in Martha's Vineyard, Massachusetts. Born in 1915 in Germany, Dr. Baum earned a medical degree from the Long Island College of Medicine in 1940 and was licensed to practice in New Jersey in 1942. During his career, he was affiliated with St. Mary's Hospital, Orange; East Orange General Hospital; and Deborah Heart and Lung Center, Browns Mills. He was a retired member of the American Medical Association, a fellow of the American College of Chest Physicians and of the Academy of Medicine of New Jersey, and a member of the American Heart Association.

Robert B. Hillsman. After 16 years of retirement, Robert Bryan Hillsman, MD, died on November 11, 1988. A member of our Bergen County component, Dr. Hillsman was living in Sarasota, Florida. Born in 1907 in Richmond, Virginia, Dr. Hillsman was awarded his medical degree in 1932 from the Medical College of Virginia; he received his New Jersey license in 1933. He was affiliated with the Department of Surgery at Holy Name Hospital, Teaneck. Dr. Hillsman was a member of the American Medical Association and was a fellow of the American College of Angiology; he served as a major in the United States Army from 1942 to 1945.

Alden P. King. A retired member of our Morris County compo-

nent, Alden Park King, MD, died on August 9, 1989. Born in 1899 in Succasunna, Dr. King received his medical degree from Jefferson Medical School, Pennsylvania, in 1924. A family practitioner, Dr. King was affiliated with Dover General Hospital and Morristown Memorial Hospital.

Joseph Newmeyer. An obstetrician/gynecologist, from Cherry Hill, Joseph Newmeyer, MD, died on August 3, 1989. Born in 1912 in Camden, Dr. Newmeyer was awarded his medical degree with the 1934 class at the University of Pennsylvania Medical School. He received his New Jersey license in 1938 and maintained a private practice in Delanco before being drafted into the military in 1942. After his tour was completed in 1946, Dr. Newmeyer reentered private practice; he retired in 1977. A member of our Camden County component and of the American Medical Association, Dr. Newmeyer was affiliated with Cooper Hospital, Camden; Zurbrugg Hospital, Riverside; and Garden State Hospital, Marlton.

Robert A. Prince. At the age of 91, Robert Anthelme Prince, MD, died on August 14, 1989. A retired member of our Passiac County component and of the American Medical Association, Dr. Prince was a surgeon from Franklin Lakes. Born in 1897, Dr. Prince received his medical degree from the University of Pennsylvania Medical School in 1931. He was licensed to practice in New Jersey in 1932. After closing his private practice, Dr. Prince served as the first direc-

tor of the emergency room at St. Joseph's Hospital and Medical Center, Paterson, until 1970. During World War II, Dr. Prince was a commander in the United States Navy medical corps.

Robert M. Shepardson. member of our Morris County component, Robert Marshall Shepardson, MD, died on August 17, 1989. Born in 1937 in Elizabeth, Dr. Shepardson was awarded his medical degree in 1964 from the Rochester School of Medicine, New York. After an internship at Jersey City Medical Center and residency at the College of Physicians and Surgeons of Columbia University, Dr. Shepardson received his New Jersey license in 1970. During his career, Dr. Shepardson was affiliated with Morristown Memorial Hospital and Community Hospital, both in Morristown. Dr. Shepardson was clinical instructor of internal medicine at UMDNJ-Rutgers Medical School, Newark.

Ralph H. VanMeter. Word has been received of the death of Ralph Harmon VanMeter, MD. A retired member of our Burlington County component, Dr. VanMeter was diplomate of the American Board of Obstetrics and Gynecology and a fellow of the American College of his specialty. Born in 1911 in Bridgeton, Dr. VanMeter earned his medical degree from Temple University School of Medicine, Philadelphia; in 1944, he received his New Jersey license. During his lengthy career, Dr. VanMeter was affiliated with Burlington County Hospital, Burlington.

NEWSWATCH

MEDICAL WASTE REGISTRATION

THE APPELLATE DIVISION OF THE SUPERIOR COURT DENIED THE MEDICAL SOCIETY OF NEW JERSEY'S REQUEST FOR AN INJUNCTION AGAINST THE NEW JERSEY STATE DEPARTMENT OF ENVIRONMENTAL PROTECTION'S REGISTRATION FEE SCHEDULE.

ALL MEMBERS OF THE MEDICAL SOCIETY OF NEW JERSEY, THEREFORE, ARE REQUESTED TO COMPLETE THE FORMS AND FORWARD THE NECESSARY FEES TO THE STATE DEPARTMENT OF ENVIRONMENTAL PROTECTION.

SINCE WE ARE CONTINUING THIS LITIGATION, WE RECOMMEND THAT YOUR CHECKS CONTAIN THE NOTATION "PAID UNDER PROTEST." THAT PHRASE IS NECESSARY TO PRESERVE YOUR LEGAL RIGHTS.



MSNJ NEWSLETTER

JOURNAL ARTICLES

With the tremendous increase in research being performed in New Jersey, the Committee on Publication voted to increase the documentation on research published in *NEW JERSEY MEDICINE*. Beginning with the January 1990 issue of our journal, all articles will include the date the article was received and the date of acceptance by *NEW JERSEY MEDICINE*. The Committee believes this policy will give authors more appropriate credit for their original research and provide for timeliness of reporting of the work being done in New Jersey.

AIDS INFECTION OF WOMEN AND CHILDREN

New Jersey currently ranks fifth in the number of reported AIDS cases with a total of 7,321 cases. Of that number, over 60 percent are known to have died. In New Jersey, the leading cause of AIDS has been intravenous drug abuse, largely in adult males. However, a growing area of concern in New Jersey is the high incidence of AIDS among women and their children. Approximately 25 percent of New Jersey's AIDS cases are women, the highest percentage reported in any state. Also, approximately 200 children currently are being treated for AIDS in the state. New Jersey has established four centers to provide services to women and children with AIDS.

NEW YORK VERSION 7 DRG GROUPER

The Department of Health has proposed to use New York's Version 7 DRG Grouper for 1990 discharges. This grouper includes 64 new DRGs which is intended more clearly to reflect the impact of comorbid conditions. A DRG also was added for patients transferred from a tertiary care facility to a community hospital for followup care. The New York Version 7 Grouper is different from the Medicare Version 7 Grouper. Medicare began using their Version 7 Grouper for discharges occurring after October 1, 1989. New Jersey hospitals will continue to use the New York Version 6 Grouper for 1989 final reconciliation purposes.

FOCUS ON COLLECTION EFFORTS

State Commissioner of Health, Molly Joel Coye, continues to stress the need for hospitals to tighten collection efforts to limit the amount of uncompensated care that is reported. The commissioner indicated that tighter controls should be implemented to guard against the potential for abuses in the system. Estimates of additional costs hospitals will incur to comply with the new procedures range from \$200,000 to \$300,000 annually. The Department has not indicated the expected additional collections hospitals will receive by implementing the new procedures. Hospitals may be required to submit "cost reduction plans" to the Department if their uncompensated care increases exceed specific Department criteria.

HCFA PUBLISHES FINAL DGME RULES

Final rules implementing changes in the manner Medicare pays for direct graduate medical education (DGME) costs were published in the September 29, 1989, "Federal Register." The changes which were mandated by the Consolidated Budget Reconciliation Act (COBRA) of 1985 are retroactive to cost reporting periods beginning on or after July 1, 1985. Medicare estimates that application of the new rules will result in annual savings ranging from \$210 million in 1990 to \$580 million in

1994, plus \$440 million in retroactive recoupments for fiscal years 198 through 1989.

DISCIPLINARY ACTIONS INCREASE

A report issued by the Federation of State Medical Boards found that the number of disciplinary actions taken by state medical boards against physicians increased by 16 percent in 1987 to 2,663 disciplinary actions. Probations and license revocations had the greatest increases at 22 percent and 17 percent, respectively. In 1986, disciplinary actions by state medical boards increased 9 percent.

EFFECTIVE MALPRACTICE COMPANIES

A study in *JAMA* concluded that physician-owned malpractice insurance companies are more effective in disciplining negligent physicians than state medical boards. The study found that the number of physicians whose insurance coverage was not renewed due to negligence was eight times higher than the number of physicians who had their license revoked or suspended by state medical boards.

AZT PRICE REDUCTION

Bowing to pressure from Rep. Henry Waxman (D-CA) and AIDS activists, Burroughs Wellcome has reduced the price of azidothymidine (AZT) by 20 percent. The price reduction came after a meeting with Waxman, chairman of the House Commerce Health Subcommittee, and followed a written request by Waxman questioning Burroughs Wellcome's research and development costs, sales revenues, and pricing strategies. AZT, whose price is \$6,400 per year for patients receiving full doses, has been found to prolong the onset of AIDS. However, Waxman and AIDS activists believe further price reductions are needed.

IG ADMITS PROFIT DROP

Health and Human Services Inspector General Richard Kusserow has issued information relative to his office's review of 1987 Medicare payments. The IG indicated that in 1987, Medicare profits dropped to \$1.1 billion as compared to \$3.8 billion a year earlier. The decline, representing a 4.77 percent margin, was due to costs being incurred by hospitals for longer stays and abnormally high increase in staff costs. Costs increased 11 percent whereas revenues went up only 5 percent. According to the IG, 57 percent of hospitals made money on Medicare. The report acknowledged the fact that rural hospitals lost on the average 4.66 percent, whereas teaching hospitals saw average profits of 7.64 percent. Urban hospitals averaged 5.71 percent profit margin. AHA referred to Kusserow's data as "ancient history" since hospitals have been losing money in the current year at a considerable pace and are expected to show losses next year to an even greater degree.

MEDICARE PAYMENT REFORM

The AMA continues to fight for Medicare payment reform. In a letter to the Health Care Financing Administration, the AMA reasserted its position on the reform. A key element in the package is a Medicare payment schedule based on an RBRVS. The AMA also pointed out that payment should not be linked to expenditure targets or mandatory assignment; expenditure targets could lead to a reduction in necessary services; and separate reductions for so-called overpriced procedures are arbitrary and unwarranted.

INTERMEDIARIES' BUDGETS CUT

The Department of Health and Human Services has directed fiscal intermediaries and carriers to begin to reduce operations so as to be able to operate within next year's reduced budget for Medicare contractors. The Blue Cross and Blue Shield Association had been looking for an increase in such payments; however, the Administration and the House are pushing for lower payments.

FINI

"It is discouraging how many are shocked by honesty and how few by deceit."



PROFESSIONAL LIABILITY

UNSUCCESSFUL TREATMENT COURSE NOT MALPRACTICE

Evidence supported a finding that a physician did not breach the standard of care in treatment of a patient for gas gangrene, a Louisiana appellate court ruled. The patient suffered injuries in an automobile accident, including a puncture tear in the area of his left buttock. The physician cleansed the wound and sutured it loosely shut, leaving space for four Penrose drains. The physician was happy with the patient's progress for about the first 24 hours.

When nurses noticed alarming changes in the patient's vital signs, they promptly notified the physician. He gave instructions to the nurses and left for the hospital. He found the patient's leg was swollen more than 40 percent and showed large blisters. He made a diagnosis of gas gangrene, administered penicillin, and assembled a surgical team for exploration and debridement. At surgery, the diseased tissue extended from the mid-thigh to the groin and above. The physician felt amputation would be ineffective, since the bacteria already had advanced into the body cavity. He considered hemicorporectomy, but decided that the patient could not survive such radical surgery. He stabilized the patient and went home, where he received hourly calls from the nurses. The patient died about 11 hours after the operation.

The patient's children brought an action for malpractice against the physician and hospital. The trial court entered judgment on a jury finding of no liability.

On appeal, the children contended that the jury's finding that the physician did not breach the standard of care was wrong. The court pointed out that an unsuccessful course of treatment was not per se an indication of malpractice. The experts agreed that gas gangrene was difficult to control, necessitating special preventive measures. The children's experts outlined steps for preventing gas gangrene. The evidence showed that for each of the steps prescribed, the physician either fully complied with it or offered a convincing explanation of why it was not advisable to comply. The court said that, considering the totality of the evidence, it could not conclude that the verdict was wrong. The children attempted to establish a standard of care and stated the opinion that the physician had breached it. The physician's experts accepted the standard in part, modified it in part, and expressed the opinion that the physician did not breach it.

The jury was within its province to accept the opinions of the physician's experts, the court said and affirmed the trial court's judgment. *Ogletree v. Willis-Knighton Memorial Hospital Inc.*, 530 So.2d 1175 (La.Ct. of App., June 1, 1988). (Reprinted with permission from *The Citation*, American Medical Association, Volume 59, May 1, 1989)

PROFESSIONAL LIABILITY

James E. George, MD, JD, is director of the Department of Professional Liability Control, MSNJ. A. Ronald Rouse is director of Special Projects, and can be reached at 609/896-1766, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648.

Former Officers Save at USAA

When you compare auto or homeowners insurance, look at all the variables.

Do you get the kind of service you deserve? Are your insurance rates competitive? Do you earn dividends? Do you share in the company's profits?

At USAA, the bottom line is VALUE. You save both time and money when you insure with us. Here's why.

SELECT, ECONOMICAL

Because of your military affiliation, you may be eligible to join USAA — a very select group.

We take pride in knowing that the members we serve (current and former commissioned and warrant officers in the U.S. armed forces) are responsible and mature drivers and property owners.

Because of the Association's selectivity, our insurance rates are highly competitive, highly desirable. But favorable rates are just a part of the USAA story.

We offer safe driver dividends, multiple car and carpooler discounts.*

When you protect your new home with USAA coverage, you can save up to 20%. And save even more by installing an approved fire and burglar protection system.

When you insure with USAA, you become an owner of the Association. And, down the road, you'll share in the company's profits through the **Subscriber's Savings Account**. This year alone, more than 480,000 members received checks totalling more than \$85 million!

TOPS IN SERVICE

Our economical coverage may bring you to us, but our service will

keep you with us. Speedy policy and claims service is bottom line. Just ask your friends who are already USAA members. And, we're always just a phone call away.

INSURANCE AND OTHER FINANCIAL SERVICES

USAA — a unique company which offers you more than auto and homeowners protection. One call can connect you to our experts in life and health insurance, mutual funds, banking services, travel, buying services. A one-stop approach to meet your special needs, designed to **SAVE YOU TIME AND MONEY**.

ONE FREE CALL

You'll find out why 9 out of 10 active duty military officers save time and money with USAA. Request a free auto or homeowners insurance rate quote. There's no obligation. Then consider the "big picture." We think you'll save with USAA. Call us today.

1-800-531-8185

*Safe driver dividends are not available in California.



Those eligible for USAA membership include anyone who is now or ever has been an officer in the U.S. military. In addition, cadets/midshipmen of the U.S. military academies, OCS/OTS candidates, ROTC cadets under government contract, and other candidates for commission are also eligible to apply for membership.



PRESIDENT'S PAGE

UNIFIED MEMBERSHIP IS UNNECESSARY

I recently attended the Annual Meeting of the Pennsylvania Medical Society (PMS). I watched as their House of Delegates overwhelmingly approved a bylaw amendment, for so-called "unified" membership with the American Medical Association. Through this mechanism, the Pennsylvania Medical Society now will require that all members of their state and county medical societies also belong to the AMA as a condition of membership.

PMS had surveyed their own county medical societies and found that the majority of their members opposed this bylaw change. Nevertheless, their House of Delegates voted, by about 75 percent to 25 percent, to require compulsory AMA membership for all PMS members.

A few weeks later, I attended the Annual Meeting of the Medical Society of Virginia, which had instituted unified membership four years ago. Under this process, they suffered a steady decrease in membership, losing more than a third of their members. The loss during this past year was the greatest of any except the very first year. Based upon a recent membership survey, they feared the loss of 50 percent of their remaining membership, if they remained a "unified" state. Their finances, and all of their programs, had suffered. There had been no benefits to offset the negative aspects of this program. They now voted overwhelmingly, 88 percent to 12 percent, to "de-unify." Now, they must begin to rebuild.

The lesson is clear.

The Medical Society of New Jersey considered and rejected unified membership several years ago. We believe that the Medical Society of New Jersey is the single most important medical organization for physicians in our state, because of our impact on health policy and public policy in New Jersey, benefiting our members, all physicians in our state, and our patients. We also encourage membership in the American Medical Association, providing representation for our membership at the national level. But, we prefer that membership in each organization be voluntary. Only in this way can we be assured that our organizations will continue to serve the best interests of our members and potential members.

PROFESSIONAL ACCOMPLISHMENT

Dr. James Quinby Atkinson, II of Burlington County has been named the recipient of the Distinguished Healthcare Professional Award of the Cooper Foundation.

This prestigious award, established in 1983, is awarded to a physician for "accomplishments and community involvement . . . to encourage and reward excellence . . . (and) to enhance public awareness of the contributions of the medical profession to society." The program has involved the medical societies of the seven counties of southern New Jersey, with an extensive nominating and balloting process.

Dr. Atkinson, a practicing physician in Burlington County for over 40

years, has been described as a champion of the handicapped, the disabled, the elderly, and the poor. He also has been very much involved with community service including the New Jersey Heart Association and the National Foundation for Birth Defects.

We are proud of Dr. Atkinson, as we are proud of the many New Jersey physicians who are dedicated to their patients, to their communities and to the citizens of our state, who serve without specific recognition and whose reward is the feeling of personal accomplishment and satisfaction that comes from being a physician.

JEMPAC LEADER

Dr. William Ryan will be leaving office as chairman of JEMPAC at the end of 1989. He will be greatly missed in that position!

Dr. Ryan has served our political action committee for the maximum time allowable. During his term of office, he not only has represented JEMPAC and led JEMPAC, but he has come to symbolize it. Throughout his tenure of leadership, JEMPAC has grown in membership, grown in funding, grown in visibility, and grown in the impact that it has in our state.

Bill has helped to show us the importance of political action, as part of our program of participation in the formation of health policy and public policy in New Jersey. Although he is leaving the leadership of JEMPAC, he will continue to serve on the Board of that organization and will continue to rise in the leadership of the Medical Society of New Jersey where he now is second vice-president.

Congratulations, Bill! □





EDITOR'S DESK

VISIONS OF SUGAR PLUMS

To eat or not to eat, that is the question. Whether 'tis nobler to suffer the slings and arrows of saturated fats or to take arms against a sea of comestibles, and by opposing, end them. Who would flabbiness bear, to grunt and to sweat under a heavy load, but that the promise of something after the New Year, that undiscovered diet plan, makes us rather bear those pounds we add, than fly to low-calorie foods we'd know not of. Thus, holidays do make cowards of us all, and thus the native hue of resolution is sicklied o'er with the shimmering hues of cranberries and plum puddings, and enterprises of great forbearance and denial lose the name of action.

The love-hate affair between Americans and their food continues unabated, markedly accentuated by the holiday season. Who is strong enough to resist completely the siren call of the delectables served at Thanksgiving, Chanukah, Christmas, and New Year's (eve and day), not to mention the innumerable business and home parties and get-togethers? Who, indeed, is strong enough? Even the white wine crowd has to watch and to count calories.

Considerably worse than the avoirdupois itself, is the layer of guilt each pound places on the conscience. For many of us are health nuts, in spirit if not in practice, and the constant bombardment, in both scientific and lay press, concerning the virtues of healthy lifestyles tends to make other lifestyles reprehensible. The relationship of diet to disease, of coronary or colon, never received more publicity than it does now, and the Federal Drug Administration and Congress are intensifying the fight to promote truth in the labeling of foodstuffs. (We wonder how they would handle nectar and ambrosia; how would they object to the claims of everlasting youth and beauty?)

If McDonald's and Domino's are close at hand, can cholesterol be far behind? If we are living longer, are we enjoying it more? Evidence suggests we are not. Does the emphasis on health make those into fitness feel punished when illness, even minor illness strikes? Evidence suggests it does. Is a healthy state—vibrant, glowing, and heavily promoted—the new religion for today? If so, are all these holiday feasts obscene? Should high-calorie recipes be censored? Perhaps we should once again follow the advice given by Oliver Wendell Holmes, Sr. in 1891: "If you mean to keep as well as possible, the less you think about your health the better."

During this month in 1776, Thomas Paine published, "These are the times that try men's souls." Little did he know how we would apply this phrase in 1989—to the overabundance of food, rather than the lack thereof, and to the desire to tighten one's belt rather than to the absolute necessity of doing so.

This month we also celebrate Forefathers' Day, commemorating the landing of the Pilgrims on Plymouth Rock in 1620. When we think of Pilgrims we think of Thanksgiving, and when we think of Thanksgiving

we think of food, partaken in peace, love, and friendship. May you have the happiest of holiday seasons and a year filled with joy and tranquility. So—"Ess, kind, ess!" Eat, drink and make merry, for tomorrow we diet.

What some call health, if purchased by perpetual anxiety about diet, isn't much better than tedious disease. (George Dennison Prentice, *Prenticeana*, 1860).

SPECIALTY SOCIETIES

The 77th Annual Meeting of the Society of Surgeons of New Jersey, held on November 1, 1989, was somewhat unique. A wide range of surgical topics was presented most eruditely, portraying the cutting edge of today's knowledge—by New Jersey physicians exclusively. Not one visiting professor made an appearance. None was needed; the depth and breadth of knowledge needed no augmentation from out of state, because New Jersey medicine has taken remarkable strides in teaching, education, research, and practice.

No longer are we the stepchildren of practitioners and institutions in New York, Philadelphia, and points distant. We should not blind ourselves to information gleaned from "abroad," but we can be proud of what we have accomplished—in both surgical and nonsurgical disciplines.

If articles and abstracts can be culled from meetings of this type for publication in *NEW JERSEY MEDICINE*, we really could put the icing on the cake.

SPECIAL BULLETIN

I hope all our readers will review carefully *Newswatch* (first page of this issue), prepared by Vincent A. Maressa, JD. In an effort to keep membership current on all legislative matters, we plan to use this "insert" column from time to time. Questions concerning the information in *Newswatch* can be directed to our executive director; comment on this new method of disseminating information to our readership should fall on my doorstep. □



BOOK REVIEWS

INFORMATION PROCESSING IN MEDICAL IMAGING

C.N. de Graaf, and M.A. Viergever (eds). New York, NY, Plenum Press, 1988. This book summarized the tenth informational symposium on information processing in medical imaging. The topics of discussion include general information processing, image reconstruction, and archiving. One section of the volume devoted to medical imaging applications is divided into digital subtraction angiography, ultrasonography, magnetic resonance imaging (MRI), and nuclear radiology. Overall, the papers varied in complexity, often relying on mathematical models. The text holds some noteworthy papers that, it should be said, assume the reader has familiarity with the field. □ Neil B. Horner, MD

MAGNETIC RESONANCE IMAGING, 2ND EDITION

C. Leon Partain, Ronald Price, James A. Patton, et al. Philadelphia, PA, W.B. Saunders Company, 1988. This is an extensive two-volume text that provides an excellent overview of both the physical basis and the clinical aspects of MRI. The book opens with an extensive physics review that is presented clearly. The range of topics is broad in scope, ranging from scan techniques, quality control, tissue characterization, and optimizing strategies; I found the discussion of the last two topics especially engrossing.

The clinically oriented chapters include all areas of the body from the central nervous system to the musculoskeletal system. Also included is a special chapter devoted to the vascular system. Each organ system is subdivided into additional areas. For example, the section devoted to MRI of the brain includes chapters on white matter disease, tumors, imaging with gadolinium, and vascular disease. Overall, the text places greater emphasis on the technical aspects of MRI than do other texts in the field. It will prove highly useful to the physician involved in magnetic resonance. □ Neil B. Horner, MD

MAGNETIC RESONANCE VIDEO REVIEW, MRI OF THE KNEE

Murray A. Solomon, MD. Magnetic Resonance Video Review, 1875 Treusdale Drive, Burlingame, CA 94010. This is a 1 hour and 49 minute videotape that depicts an extensive review of the knee. The discussion is complete and enjoyable to view. In presenting the techniques he uses at his MRI sites in California, Dr. Solomon opens with a discussion of normal anatomy and highlights the normal variants that may mislead one in scan interpretation. There is extensive coverage of the most common knee injuries, such as meniscal tears and ligament injuries. Other areas are discussed, for example, trauma and neoplasms. The scans, too numerous to count, are consistently of good quality, and Dr. Solomon's narration is excellent. The tape is highly recommended to the physician who has interest in the field, thus including radiologists, orthopedic surgeons, and rheumatologists. □ Neil B. Horner, MD

PEDIATRIC CARDIOLOGY FOR PRACTITIONERS

M.K. Park. Chicago, IL, Year Book Medical Publishers, 1989. Dr. Park has succeeded admirably in meeting the needs of "noncardiologist practitioners" who deal with children in whom heart disease is suspected. The cognoscenti readily will discover much to nit-pick, but this book was not intended for them.

The first part, devoted to basic tools in cardiac diagnosis, is a superb review of history taking, physical examination, basic electrocardiography, and interpretation of plain chest x-rays highlighted by a flow diagram that illustrates how these simple office methods may be used to arrive at specific diagnoses. This is followed by a less impressive section on special tools in diagnosis including both invasive and noninvasive procedures. My major criticism of this otherwise remarkable synopsis is Dr. Park's parsimonious treatment of echocardiography. While it was not his intent to discuss this subject in depth because of the limitations of his targeted audience, nevertheless even the most antiquated pediatric cardiologist begrudgingly will admit that echocardiography is superior to other noninvasive, and even invasive, procedures as a diagnostic modality.

A terse analysis of the pathophysiology of shunting and valvar lesions is followed by traditional chapters on the more common congenital and acquired cardiac disorders. The book concludes with a potpourri of information on neonatal problems, congestive heart failure, systemic and pulmonary hypertension, hyperlipidemia, postoperative syndromes, and the differential diagnosis of chest pain and syncope in children. There even is an appendix that lists doses, toxicity, and side effects of drugs often used in pediatric cardiology.

I recommend this book heartily to medical students, house staff, and noncardiologist practitioners. While the experienced pediatric cardiologist may be quick to point out errors owing to oversimplification, I suspect that even he covertly will admit to having found some nuggets to be nurtured. □ Edwin L. Rothfeld, MD

YEAR BOOK OF OPHTHALMOLOGY

J. Terry Ernest, MD, PhD. Chicago, IL, Year Book Medical Publishers 1988. The Year Book of Ophthalmology provides a useful update on many conditions and diseases that affect the eye. The format for each chapter consists of a summary of the latest information on these conditions following which a number of timely and selective articles are presented and then critiqued by the editor.

Since it is impossible to review extensively every aspect of disease of the cornea, cataracts, retina, glaucoma, neuro-ophthalmology, pediatric ophthalmology, and uveal diseases, only certain aspects are covered in the book. Nevertheless, those subjects covered can provide for some stimulating and informative reading. □ Alfonse A. Cinotti, MD

ADVANCES IN PEDIATRIC SPORT SCIENCES

Oded Bar-Or (ed). Champaign, IL, Human Kinetics Books. This book is one of a series of volumes produced to cover various biological and behavioral issues related to pediatric sports science. This third volume covers biological topics such as developmental maturity, muscle power, oxygen transport, weight training, anaerobic thresholds in pediatric exercise testing, iron deficiency, exercise-induced bronchial asthma, juvenile hypertension, and cardiovascular indices in exercise testing.

The book is of primary interest more to the exercise physiologist than the clinician, but does contain a wealth of material on the subject addressed. It is written by separate authors for each chapter, but seems generally consistent in style. There are no illustrations, but numerous graphs relative to the subjects discussed are used. Each chapter has its own bibliography.

The main value of the book is for the researcher in pediatric sport medicine and for that individual it is a good addition to the library shelf. □ Christine Haycock, MD

Asthma Due to Parasitic Infestation

WILLIAM D. STRAZZELLA, DO
BENJAMIN H. SAFIRSTEIN, MD

The authors document the association between refractory asthma, eosinophilia, pulmonary infiltrates, and diarrhea due to parasitic hyperinfestation resulting from Strongyloides stercoralis.

Strongyloides stercoralis has worldwide distribution but is most common in tropical and subtropical climates.¹ In the United States, Strongyloides is endemic in the Southwest and also is found in urban areas with large immigrant populations. With the influx of a large number of refugees from developing countries and the wide-ranging travel patterns of some North Americans, there has been an increase in the frequency of pulmonary disease of parasitic origin in the United States.⁴ The following case report documents the development of severe respiratory distress as a result of Strongyloides hyperinfestation.

CASE REPORT

A 59-year-old Ecuadorian male was admitted for the second time to Saint Michael's Medical Center for abdominal pain, progressive leg edema, and a 20-pound weight loss. He had been admitted six months previously for similar symptoms and severe asthma. He had longstanding asthma since childhood and had emigrated to the United States, seeking therapy for severe respiratory distress. As a child, he was treated for intestinal worms. He had undergone an appendectomy and cholecystectomy and was under treatment for hypertension and congestive heart failure.

During his first admission, six months before, he was found to have severe reversible air flow obstruction. His FEV₁ of 1.75 L rose to 2.2 L following bronchodilators. He had a hemoglobin of 12.6 gm percent with a total white blood cell count of 11,400. A differential smear demonstrated 44 percent

Dr. Strazzella is a pulmonary and critical care fellow and Dr. Safirstein is director of pulmonary medicine, Department of Medicine, Saint Michael's Medical Center, Newark. Requests for reprints may be addressed to Dr. Safirstein, Saint Michael's Medical Center, 268 Martin Luther King Jr. Blvd., Newark, NJ 07102.

eosinophils. Radiographic evaluation of the chest, small bowel, and large bowel were normal, as were colonoscopy, endoscopicretrograde cholangiopancreatography (ERCP), and computerized axial tomography of the abdomen and pelvis. Right heart catheterization was normal and failed to document left ventricular dysfunction. He was treated for asthma with increasing doses of prednisone and inhaled albuterol, and was discharged in improved condition.

As an outpatient, he developed increasing dyspnea despite steroids, and progressive anorexia, weight loss, abdominal pain, and distention.

He was readmitted for severe unresponsive asthma and progressive abdominal distention. Examination revealed a chronically ill Ecuadorian male in severe respiratory distress with bilateral rhonchi and wheezing. His abdomen was distended but no organ enlargement was found. Edema was present to his mid-thigh. Hemoglobin was at 13.4 gm percent with normal total white blood count (WBC) and differential. Liver function studies were abnormal with marked reduction in total albumin and cholesterol. Spirometry demonstrated an FEV₁ of 0.8 L and his forced vital capacity (FVC) was measured at 1.6 L. Initial radiographs of the chest were normal. Despite intravenous steroids and bronchodilators, he progressed to respiratory insufficiency requiring intensive care monitoring. On the third hospital day, he developed severe diarrhea and gram-negative sepsis. Cultures of stool were unremarkable for bacteria but contained first- and third-stage *Strongyloides stercoralis* larvae. Repeat radiographs of the chest demonstrated infiltrates in the right lower lobe. He received five days of thiabendazole 25 mg/kg/day, which resulted in a marked improvement in his respiratory status. Repeat chest radiographs demonstrated clearing of the right lower lobe infiltrate. His appetite improved, edema and eosinophilia cleared, and liver function tests returned to normal.

DISCUSSION

Strongyloides is unusual among the intestinal helminths. Under conditions of immunosuppression, *Strongyloides* can disseminate widely throughout the body, causing serious and often fatal infection. Secondly, its cycle of auto infection allows it to reside in the host, allowing the potential for producing illness more than 35 years after the patient has left an endemic area.^{5,6} Most often, overwhelming infections appear as opportunistic infection in patients with advanced renal disease, or a malignant lymphoma, especially after treatment with corticosteroids or immunosuppressive agents. Steroid therapy, even when given for benign conditions such as asthma, enhances the transformation of rhab-

diform larvae into invasive filariform larvae in the intestines.^{7,8}

Strongyloides can exist in warm, moist soil as free living adult forms, independent of the human host. Ova hatch into rhabdiform (nonmigratory) larvae which either mature into noninfectious adults or filariform infective larvae. Initially, the patient's skin contacts contaminated soil or feces and the filariform larvae penetrate the dermis. They migrate through the venous system to the right side of the heart, and then lungs, where they penetrate into the alveolar spaces. After migrating up the trachea, the larvae are swallowed and reach their preferred site in the duodenum and proximal jejunum; here they become hermaphroditic and can lay up to 40 eggs per day. Ova deposited in the mucosa develop into rhabdiform larvae which are shed from the bowel and excreted in the feces.¹ This assures the soil based exogenous cycle and subsequent transmission to other hosts.

Three mechanisms explain the pulmonary involvement of *Strongyloides*:

First, during the primary migratory phase through the lung, larvae reach the pulmonary capillaries perforate the alveolar-capillary membranes, and enter the aveoli with resultant alveolar hemorrhage, edema, and desquamation of epithelial cells. The migration of macrophages and inflammatory cells produce alveolar consolidation and pneumonitis. However, the pulmonary lesions not only are produced by the larvae migrating through the lung parenchyma, but also are a result of the presence of two types of antibodies, the reaginic IgE antibody (type I) responsible for asthma and urticaria, and IgM precipitating antibody (Type III) resulting in pulmonary infiltrates similar to the mechanism of allergic bronchopulmonary aspergillosis (Type IV). Delayed hypersensitivity also may play a factor, resulting in granuloma formation at the sites where eggs lodge.^{10,11}

Secondly, the migration of larvae up the trachea may be retarded by excessive bronchial secretions, inflammation, or plugging resulting in adult females producing progeny, and the respiratory system may harbor the organisms for a long time. Manifestations of chronic bronchitis, airway obstruction, and bronchospasm result. During this phase, sputum examination may demonstrate rhabdiform larvae and *Strongyloides* ova. Although rare, the rhabdiform larvae may disseminate throughout the lung producing complications such as bronchopneumonia, hemoptysis, pleuritis with hemorrhagic pleural effusion, pericarditis, and respiratory failure.^{3,5,8,12}

The hyperinfection syndrome is a third mechanism producing pulmonary involvement with *Strongyloides*, unlike most other helminths. In ordinary circumstances, the vegetative rhabdiform larva

are produced in the crypts of the duodenal and jejunal mucosa, then pass out in the feces in that form; they transform into the infective filariform type of larvae outside the body. Sometimes, however, the invasive filariform larvae form within the bowel lumen and invade the wall by "internal auto-infection" to cause further episodes of pulmonary migration, consequently increasing the chances of a persistent bronchial infection.^{3,13} Fifty percent of otherwise healthy human hosts harbor the parasite without symptoms; the remainder usually have only mild gastrointestinal manifestations. Tissue invasion does not occur in the normal host, probably because of effective cellular immunity. Systemic strongyloidosis usually develops in a setting in which hosts defenses become compromised. In an immunocompromised host, this process may lead to massive proliferation of larval forms as well as to the dissemination of the parasite's life cycle. Protean gastrointestinal manifestations, pulmonary involvement, altered mental status, gram-negative bacteremia, and the presence of filariform larvae in sputum and feces characterize the clinical syndromes of hyperinfection and disseminated strongyloidosis.^{6,13,14}

The diagnosis ultimately requires identification of the parasite in sputum, stool, or pleural fluid. Multiple fresh concentrated fecal samples identify *Strongyloides stercoralis* infection less than 30 percent of the time. Duodenal aspirate and jejunal biopsy produce the diagnosis in approximately 90 percent of cases.^{3,6,13} Eosinophilia correlates with recurrent larval tissue invasion. However, in patients on steroid therapy, eosinophilia may be suppressed. Only 20 percent of the patients who are seriously ill with hyperinfection have an elevated eosinophil count.^{3,4}

In most cases of alimentary strongyloidiasis,

thiabendazole, 25 mg/kg twice daily for two days, has been successful. Pulmonary and disseminated strongyloidiasis are treated with thiabendazole, 25 mg/kg orally twice daily for a minimum of five days.^{3,6,13} Repeated sputum and stool cultures for parasites will help confirm eradication of infection and retreatment is indicated if infection persists or recurs. In cases of thiabendazole resistance, infections have responded to pryzium pamoate and diethylcarbamazine.^{8,15}

Our case presentation emphasizes the importance of acknowledging a patient's geographic background, either by origin or travel, and the danger in converting a subtle parasitic intestinal infestation into a life-threatening hyperinfection with dissemination.

Although we recovered the parasite in the stool, we feel our patient manifests all phases of the life cycle of *Strongyloides stercoralis*. The history of endemic exposure with recurrent refractory bronchospasm represented "internal autoinfection."^{7,13} This typically progressed to hyperinfection with dissemination following steroid therapy. This was manifested by multiple organ system involvement including pneumonitis with lobar consolidation, gram-negative septicemia, and abdominal pain with weight loss and diarrhea.⁴ This clinical impression was confirmed by resolution of his symptoms following treatment with the antihelminthic, thiabendazole.

We urge, as have several others,^{3,6,8,13} the routine examination of multiple stool and sputum specimens prior to the use of corticosteroid therapy in patients with a history of residence or travel to endemic regions for parasites. This especially is important with the increasing use of steroids to treat late inflammatory phase asthma, and the continued influx of immigrant populations to urban areas. ■

REFERENCES

1. Craig EC, Russell PF, Jung RC (eds): *Craig and Faust's Clinical Parasitology, 8th Edition*. Lea and Febiger, Philadelphia, PA, 1970.
2. Marcial-Rojas RA: Strongyloidiasis, in Marcial-Rojas RA (ed), *Pathology of Protozoal and Helminthic Diseases*. Baltimore, MD, Williams and Wilkins, 1971.
3. Higenbottam TW, Heard BE: Opportunistic pulmonary strongyloidiasis complicating asthma treated with steroids. *Thorax* 31:226-33, 1976.
4. Barrett-Conor E: Concise clinical studies: Parasitic pulmonary disease. *Am Rev Respir Dis* 126:558-563, 1982.
5. Kyle LH, McKay DG, Sparling HJ: Strongyloidiasis. *Ann Intern Med* 29:1014-1042, 1948.
6. Scowden EB, Schaffner W, Stone WJ: Overwhelming strongyloidiasis. *Medicine* 57:527-544, 1978.
7. Harley JP, Gallicchio V: Effect of cortisone on the establishment of *Nippostrongylus brasiliensis* in the rabbit. *J Parasitology* 58:271-276, 1970.
8. Nwolkolo C, Imohiosen EAE: Strongyloidiasis of respiratory tract presenting as "asthma." *Br Med J* 2:153-154, 1973.
9. Faust EC: Experimental studies on humans and primate species of *Strongyloides*. *Arch Pathol* 18:796-806, 1935.
10. McCombs RP: Medical progress: Disease due to immunologic reactions in the lungs (second of two parts) *N Engl J Med* 286:1245-1251, 1972.
11. Phills JA, Harrold JA, Whiteman GV, Perelmutter L: Pulmonary infiltrates, asthma and eosinophilia due to *Ascaris suum* infestation in man. *N Engl J Med* 288:965-970, 1972.
12. Froes HP: Identification of nematode (*Strongyloides stercoralis*) larvae in exudate of serohemorrhage pleural effusion. *J Trop Med* 33:18-19, 1930.
13. Bruno P, McAllister K, Mathews J: Pulmonary strongyloidiasis. *South Med J* 75:363-365, 1982.
14. Scully RE, Mark EJ, McNeely WF, McNeely BV: Case records of the Massachusetts General Hospital, Case 47-1987. *N Engl J Med* 317:1332-1342, 1987.
15. Wang CC, Galli GA: Strongyloidiasis treated with pryzium pamoate. *JAMA* 193:191, 1965.

INNOVATIVE MEDICAL SYSTEMS, INC.

... Doing what *WE DO BEST*, so you
can do what you do best



THE IMS ADVANTAGE

- IMS has demonstrated its success by **INCREASING COLLECTIONS AND CASH FLOW** WHILE **ENHANCING THE PHYSICIAN'S PROFESSIONAL IMAGE**
- IMS is a fully **BONDED ORGANIZATION OF MEDICAL MANAGEMENT SPECIALISTS** with over **15 years experience** in practice management.

FOR INFORMATION CONTACT: 609-770-1160
GLENDALE EXECUTIVE CAMPUS • 1000 WHITE HORSE ROAD
SUITE 512 • VOORHEES, NEW JERSEY, 08043

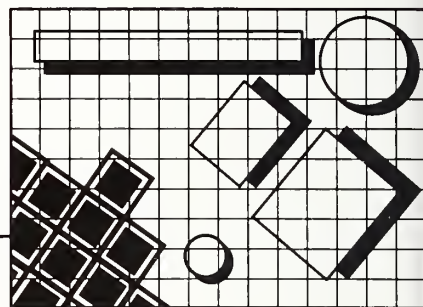
S P A C E / C O L O R



IT TAKES A LOT MORE THOUGHT TO CREATE AN OFFICE ENVIRONMENT

It is the delicate blending of space, color, texture, and style to create a unique impression, one that reflects your professional image, in every corner, down to the smallest detail. So, no matter what your requirements are, plan on a perfect office.

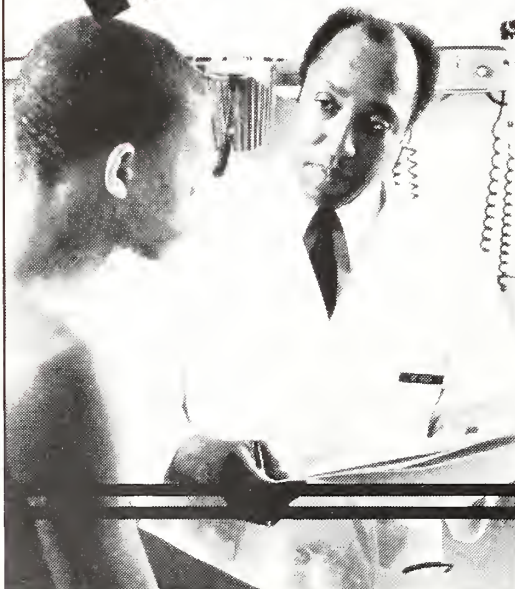
Custom Interior Design For Business.
Consultations Invited.



MAX
deco

INTERIOR DESIGNS, INC.
COMMERCIAL / RESIDENTIAL (201) 821-7850

AIM HIGH



CREATE A MEDICAL BREAKTHROUGH.

Become an Air Force physician and find the career breakthrough you've been looking for.

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay per year

Today's Air Force provides medical breakthroughs. Find out how to qualify as a physician or physician specialist. Call

USAF PHYSICIAN PLACEMENT
1-800-423-USAF



Lung Cancer

Difference in Age at Diagnosis Between Men and Women

PERRY A. SCHEINOK, PhD
PETER E. ENGLER, PhD
PATRICIA D. ROBERTSON, BA
ROBERT V.P. HUTTER, MD
DONALD E. HENSON, MD

The analysis of a data file comprising 776 lung cancer patients from the Tumor Registry at a 705-bed community hospital in New Jersey reveals that women are diagnosed with squamous cell and large cell lung cancer at an earlier age than men.

In 1987, investigators in the province of Saskatchewan, Canada, using information from 927 patients obtained from the Saskatchewan Cancer Foundation Tumor Registry, reported that

women were diagnosed as having lung cancer at a younger mean age than males ($X \pm SE$, $63.5 \pm .85$ years versus 67.6 ± 0.37 years, $P < 0.001$), a finding consistent for each major histologic category.¹

Drs. Scheinok and Engler are affiliated with the New Jersey Institute of Technology. Dr. Hutter and Ms. Robertson are affiliated with Saint Barnabas Medical Center, Livingston. Dr. Henson is affiliated with the National Cancer Institute, Bethesda, MD. Requests for reprints may be addressed to Dr. Engler, Electrical Engineering Department, New Jersey Institute of Technology, 323 Martin Luther King Jr. Blvd., Newark, NJ 07102.

In 1984, our group, using data retrieved from the computerized Tumor Registry at Saint Barnabas Medical Center (SBMC), a 705-bed tertiary care referral center in Livingston, discovered both similar and dissimilar results. Analysis of the data, taken as a whole and irrespective of histological classification, revealed that 39.1 percent of the females were diagnosed with lung cancer before the age of 60, compared with 28.0 percent of the males. These

data were compared to the National Cancer Institute's Surveillance, Epidemiology, and End-Results (SEER) data, a national database, which revealed that 35.7 percent of the females diagnosed were under age 60, while only 29.3 percent of the males were diagnosed at age less than 60.

Dissimilar results were obtained when SBMC and SEER data were subdivided into the four major histological lung cancer categories: squamous cell carcinoma; large cell carcinoma; adenocarcinoma; and small cell carcinoma. For SEER data, the male/female age-at-diagnosis disparity is present in all histological categories; SBMC data, however, reveal a statistically significant difference in age at diagnosis for only the large cell and squamous cell carcinomas, and no statistically significant difference in the age at diagnosis for the adenocarcinomas. For the small cell carcinomas, the SBMC database yields somewhat inconclusive statistical results, to be discussed later. The authors of the Saskatchewan study found women were diagnosed at an earlier age than men for each of major histological categories, which is in agreement with the analysis of the SEER data. The data from that study are derived from the Saskatchewan Cancer Foundation which, like the SEER data file, is a population-based registry.

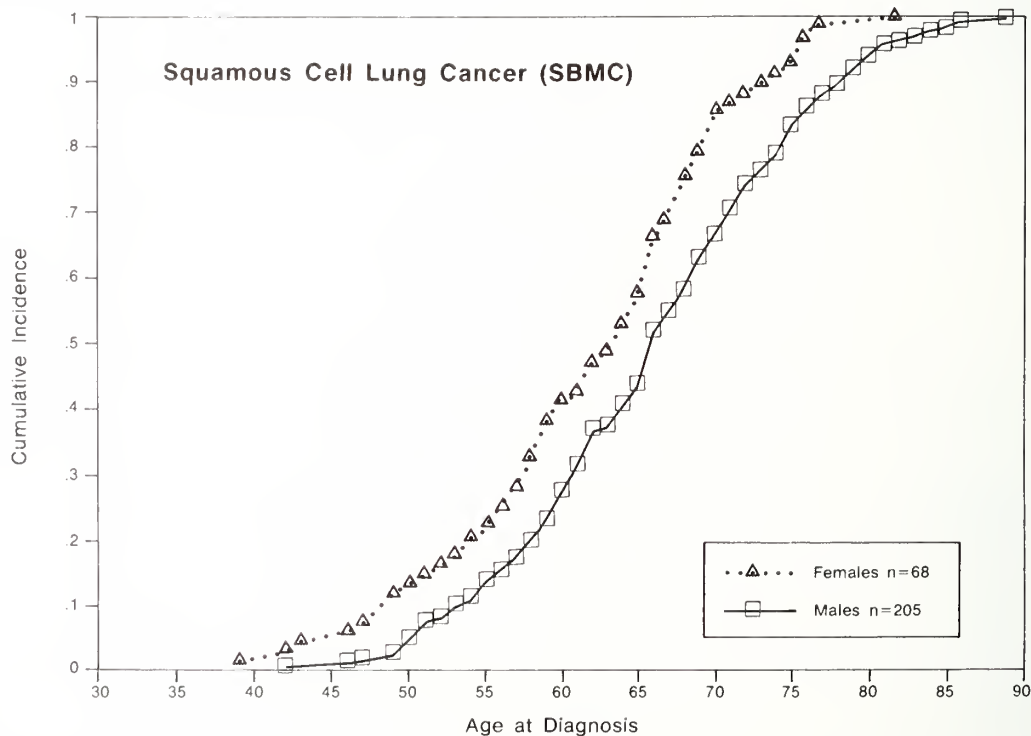
MATERIALS AND METHODS

The SBMC Tumor Registry is part of a cancer program, approved by the American College of Surgeons Commission on Cancer, to collect data on all cancer patients diagnosed and treated as inpatients or outpatients at SBMC. As a referral center for northern New Jersey, SBMC offers a full range of treatment for lung carcinoma patients, including surgery, radiation therapy, and chemotherapy.

This study included all patients histologically diagnosed and treated at SBMC between January 1, 1974, and December 31, 1983. Cancers diagnosed as carcinoids and as "not otherwise specified" (NOS) were excluded from the study.

Histologic classifications were made from pathology reports of patients diagnosed at SBMC from the review of slides or from the reports of referring institutions prior to the patients' treatment at SBMC. Classification codes originally were assigned from the *Manual of Tumor Nomenclature and Coding Scheme (MOTNAC)*, which subsequently was replaced by the *International Classification of Diseases for Oncology (ICD-O)*.

The SEER Program is a population-based tumor registry that is supported by the National Cancer Institute.^{2,3} It monitors approximately 10 percent of the United States population. The registry covers



D = 0.19, Chi² = 7.4, P = 0.025

Figure 1A. Distribution of the cumulative incidence as a function of age at diagnosis for 205 male and 68 female squamous cell lung cancer patients diagnosed and treated at SBMC between 1974 and 1983. The parameter D is the maximum vertical separation between the male and female curves and is used to determine the P value by the Kolmogorov-Smirnov test.

the states of Iowa and Connecticut as well as seven large metropolitan areas. The SEER data bank incorporates data from 1973 through 1985; the data also are coded according to the *MOTNAC* and *ICD-O* classification schemes.

RESULTS

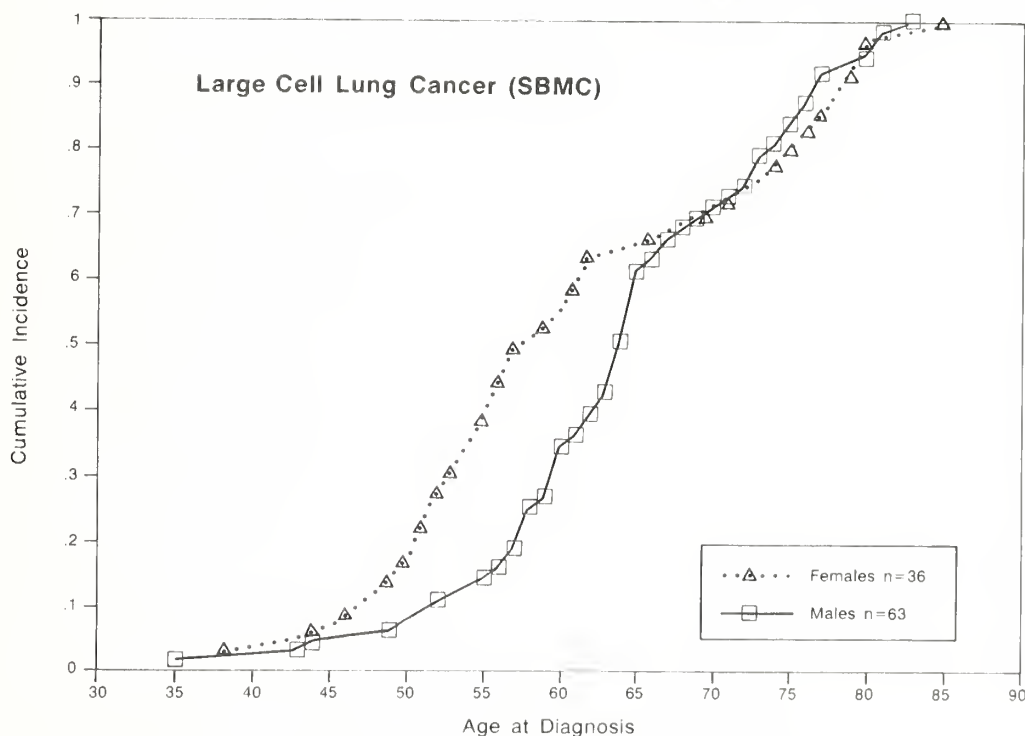
The SBMC data file comprises 515 male and 261 female patients diagnosed with primary lung cancer at SBMC from 1974 to 1983. There were 102 (39.09 percent) female patients diagnosed with lung cancer before the age of 60, compared to 144 (27.96 percent) male patients. Using 2 x 2 contingency tables, it was determined that the relatively large number of females compared to males who were diagnosed before the age of 60 at SBMC is statistically significant at $P < .002$.

The SEER database of 66,410 lung cancer cases was compiled in the time period 1977 to 1984. Review of that much larger database revealed 35.67 percent of 19,677 females diagnosed in this five-year time period were under age 60, while only 29.26 percent out of 46,733 males were diagnosed at age less than 60. Because of the large numbers involved, the Chi-square statistic for this contingency table yields a high statistical significance of $P < 10^{-6}$.

SBMC and SEER data here are subdivided into

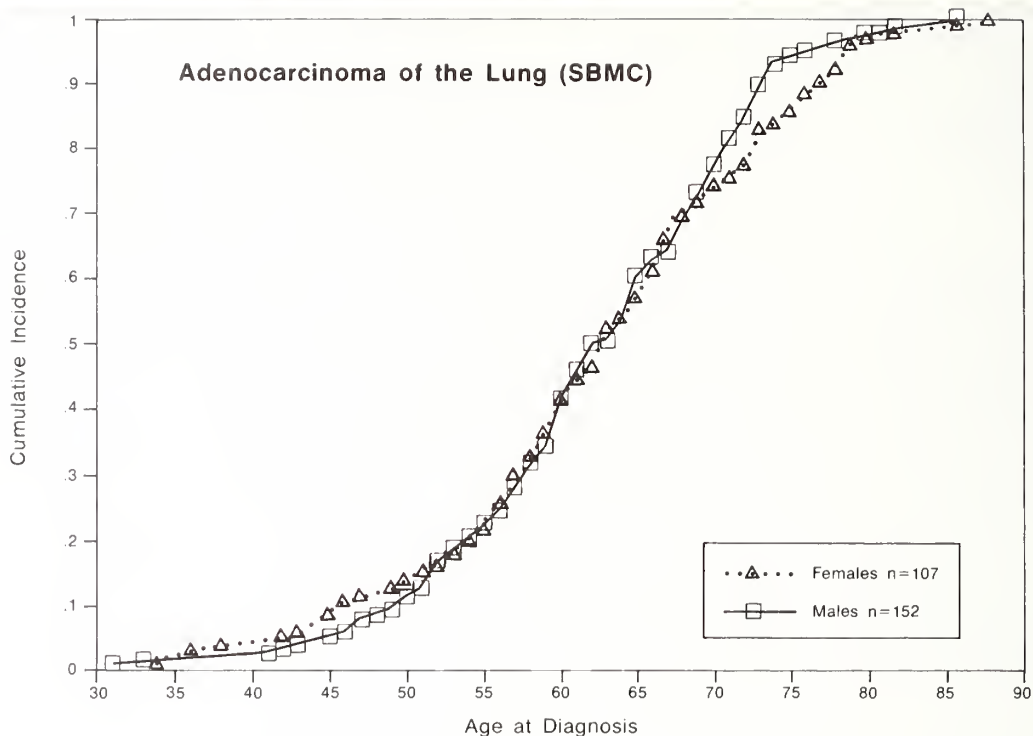
the four major histologic categories and examined by developing cumulative incidence curves for both male and female lung cancer patients (Figures 1 and 2). The Kolmogorov-Smirnov one-tailed test is applied to the curves. (The SEER incidence, Figure 2, was reported in five-year age groupings.) This test is a measure of the statistical significance of the difference between the male and female cumulative incidence distributions—the test of choice for this study.⁴ The variable D , which is used to determine the statistical significance of this difference, is the maximum vertical separation between the two curves on Figures 1 and 2. According to Figure 2, the separation between male and female distribution curves for SEER data are statistically significant for all four major histologic categories. This is qualitatively evident as the distributions for the female curves distinctly are separate from the male distribution curves. (In Figure 2C, the adenocarcinoma male distribution curve crosses the female curve at age 69; at that age, 71 percent of the males and 73 percent of the females already had been diagnosed. We feel this late crossover does not contradict the observation that the SEER data show females are diagnosed with adenocarcinoma of the lung at a younger age than males.)

For SBMC data, the Kolmogorov-Smirnov test yields a statistically significant difference between



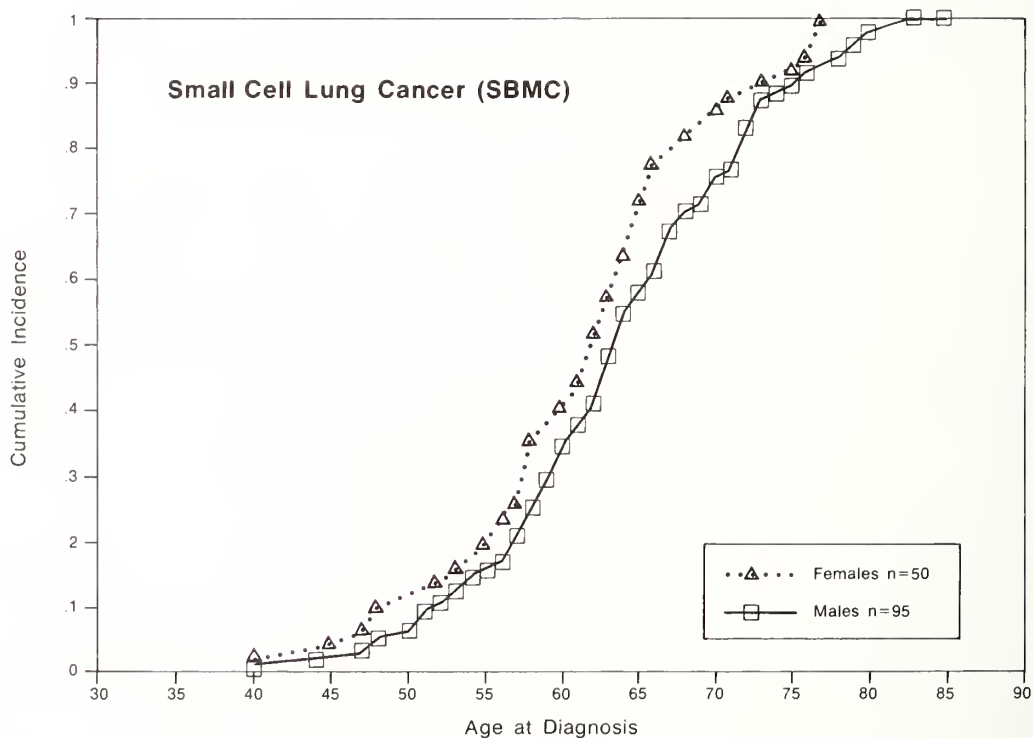
$D = 0.31$, $\text{Chi}^2 = 8.8$, $P = 0.012$

Figure 1B. Distribution of the cumulative incidence as a function of age at diagnosis for 63 male and 36 female large cell lung cancer patients diagnosed and treated at SBMC between 1974 and 1983. The parameter D is the maximum vertical separation between the male and female curves and is used to determine the P value by the Kolmogorov-Smirnov test.



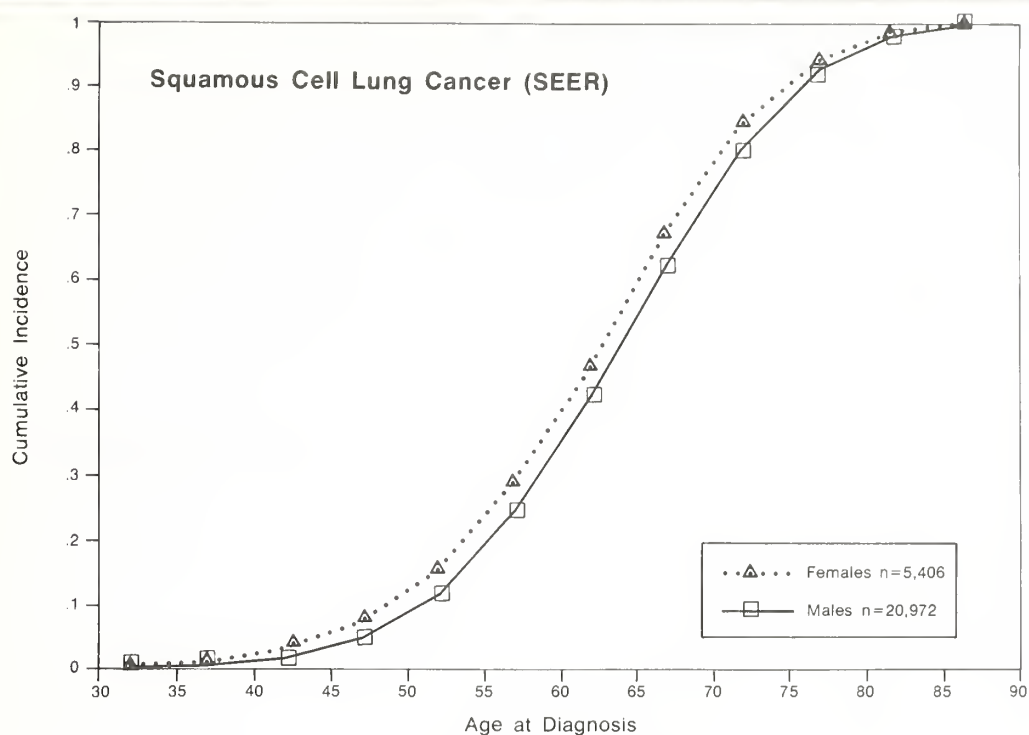
$D = 0$, No statistically significant separation between curves.

Figure 1C. Distribution of the cumulative incidence as a function of age at diagnosis for 152 male and 107 female adenocarcinoma lung cancer patients diagnosed and treated at SBMC between 1974 and 1983. The parameter D is the maximum vertical separation between the male and female curves and is used to determine the P value by the Kolmogorov-Smirnov test.



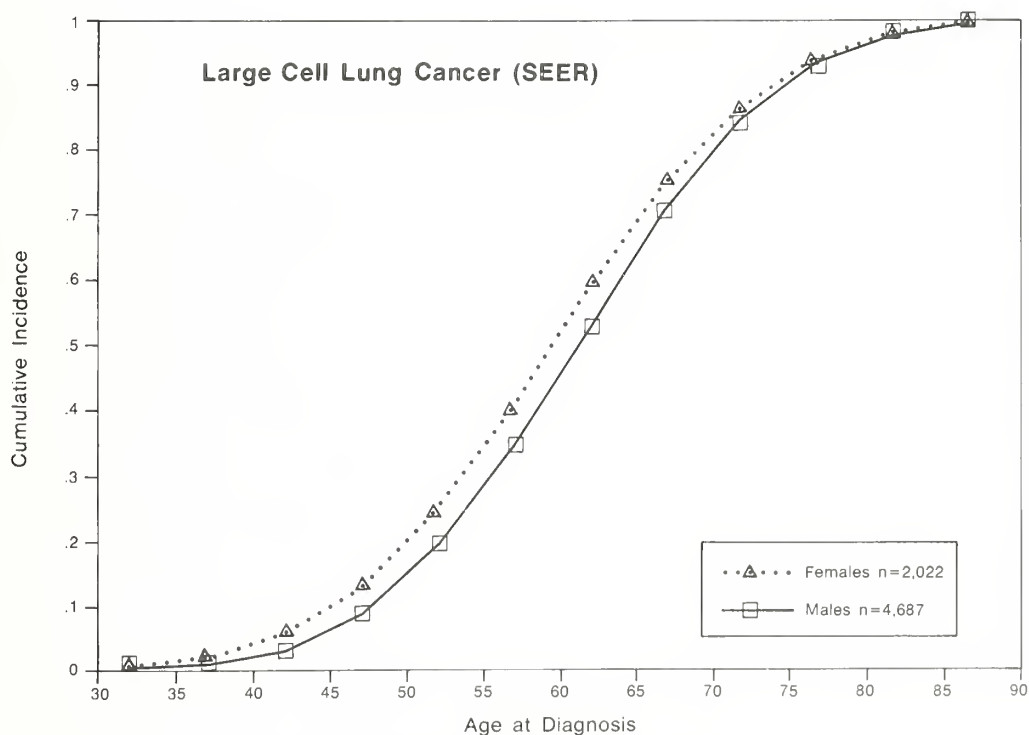
$D = 0.169$, $\text{Chi}^2 = 3.7$, $P = 0.154$

Figure 1D. Distribution of the cumulative incidence as a function of age at diagnosis for 95 male and 50 female small cell lung cancer patients diagnosed and treated at SBMC between 1974 and 1983. The parameter D is the maximum vertical separation between the male and female curves and is used to determine the P value by the Kolmogorov-Smirnov test.



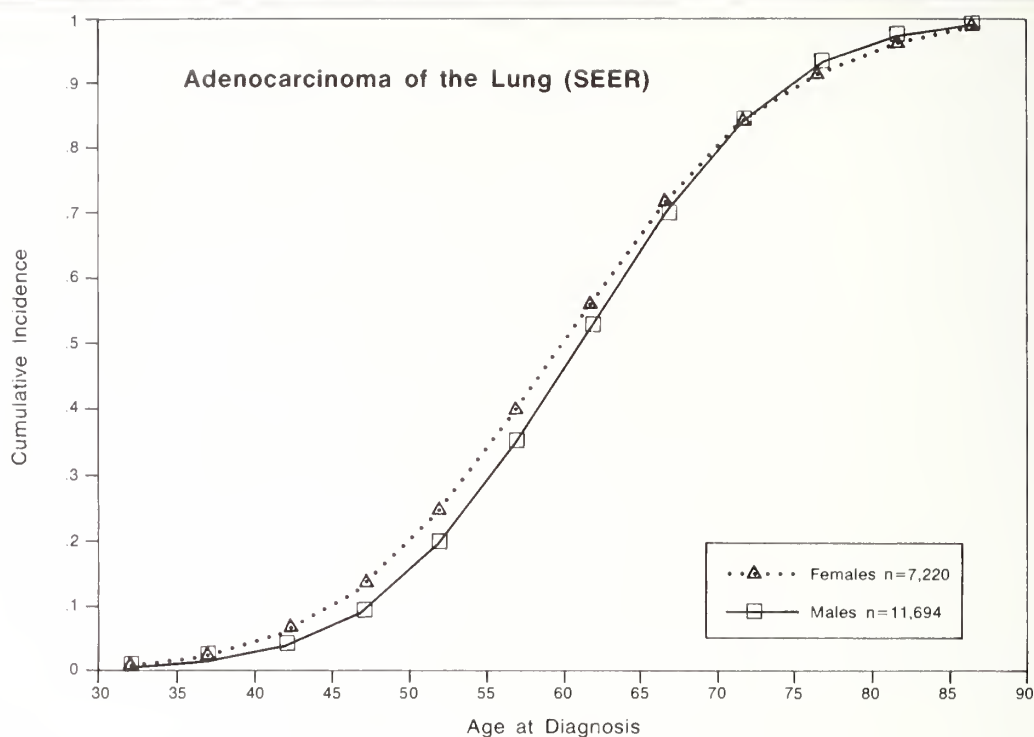
$D = 0.053$, $\text{Chi}^2 = 48.3$, $P < 10^{-6}$

Figure 2A. Distribution of the cumulative incidence as a function of age at diagnosis for 20,972 male and 5,406 female squamous cell lung cancer patients reported by SEER between 1977 and 1984. Age at diagnosis is reported in five-year increments. The parameter D is the maximum separation between the male and female curves and is used to determine the P value by the Kolmogorov-Smirnov test.



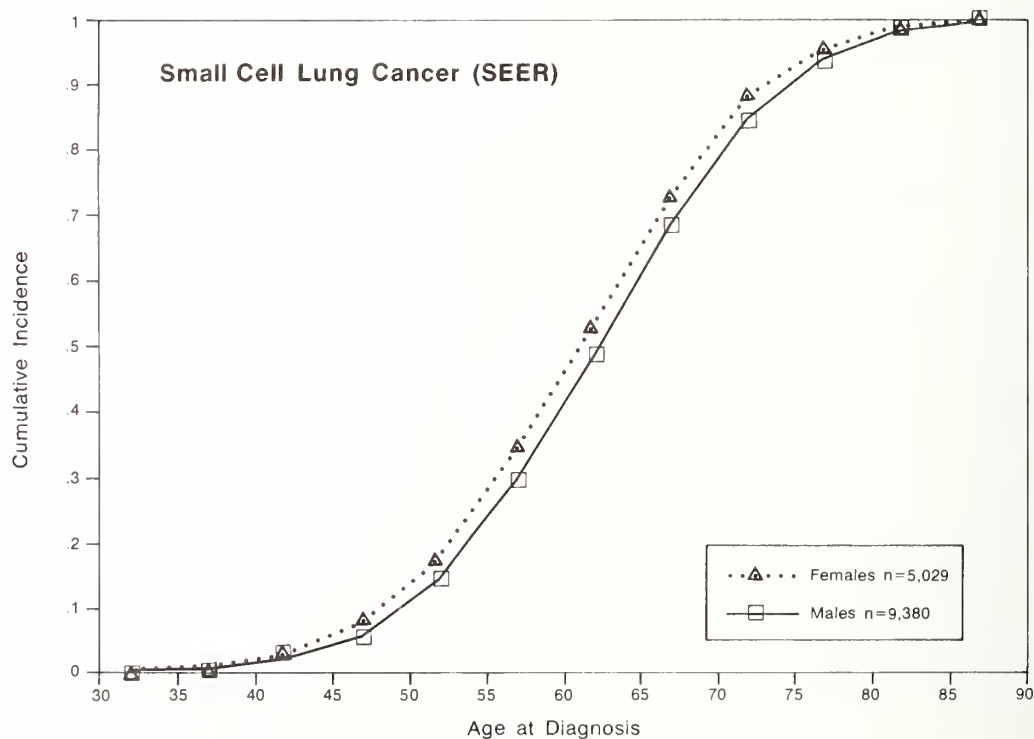
$D = 0.063$, $\text{Chi}^2 = 22.5$, $P = 1.3 \times 10^{-5}$

Figure 2B. Distribution of the cumulative incidence as a function of age at diagnosis for 4,687 male and 2,022 female large cell lung cancer patients reported by SEER between 1977 and 1984. Age at diagnosis is reported in five-year increments. The parameter D is the maximum separation between the male and female curves and is used to determine the P value by the Kolmogorov-Smirnov test.



$D = 0.043, \text{Chi}^2 = 41.0, P < 10^{-6}$

Figure 2C. Distribution of the cumulative incidence as a function of age at diagnosis for 11,694 male and 7,220 female adenocarcinoma lung cancer patients reported by SEER between 1977 and 1984. Age at diagnosis is reported in five year increments. The parameter D is the maximum separation between the male and female curves and is used to determine the P value by the Kolmogorov-Smirnov test.



$D = 0.045, \text{Chi}^2 = 26.4, P = 1.9 \times 10^{-6}$

Figure 2D. Distribution of the cumulative incidence as a function of age at diagnosis for 9,380 male and 5,029 female small cell lung cancer patients reported by SEER between 1977 and 1984. Age at diagnosis is reported in five-year increments. The parameter D is the maximum separation between the male and female curves and is used to determine the P value by the Kolmogorov-Smirnov test.

the male/female cumulative incidence versus age distributions for only the squamous cell and large cell categories; the male and female curves in Figures 1A and 1B clearly belong to two distinct populations. In Figure 1D, SBMC distributions for small cell lung cancer, the male and female curves appear distinctly separate, and give us a possible indication that the two populations are indeed distinct, yet the mathematics yields a P value as large as .154. A possible reason might be that there were only 95 males and 50 female patients with small cell lung carcinoma entered into the SBMC data file; if the same curves were derived from populations comprising 190 males and 100 females, in the same 1.9:1 ratio, a statistically more significant P value between .02 and .05 would have been obtained. SBMC adenocarcinoma distributions in Figure 1C, on the other hand, virtually are congruent in the 50-to-70-year age interval where the curves are steepest, and we expect that the statistical null hypothesis would not be rejected even with a much larger data base. It is interesting to note that in Figure 1C the female distribution curve for adenocarcinoma from the SBMC data crosses the male curve at about the same age-at-diagnosis coordinate as in the SEER adenocarcinoma distribution in Figure 2C.

The Canadian group reports the age disparity to be present in each histologic category, as is the case for the SEER database. In tabulating the distribution of cell type by gender, however, they noted men have an excess of squamous cell carcinomas, and deficits of adenocarcinomas and large cell carcinomas. These results are at variance with SBMC and the SEER databases in which the frequency of occurrence of all four histologic categories significantly is higher in males than in females.

DISCUSSION

For the SBMC data, the absence of disparity between the age-at-diagnosis distribution curves for males and females for adenocarcinoma (Figure 1C), and possibly for small cell carcinoma (Figure 1D), certainly seems noteworthy. Are SBMC data different from corresponding SEER data?

SBMC is a voluntary, tertiary-care referral center with a relatively homogeneous geographic, ethnic, and socioeconomic patient data source. The SEER database, on the other hand, is population-based and has been devised carefully to represent a heterogeneous sample of the United States population. The interesting problem then is to identify the factor that protects the general United States population male from adenocarcinoma of the lung for two to three years, relative to the female patient, but is absent in the male patient in the SBMC Tumor Registry.

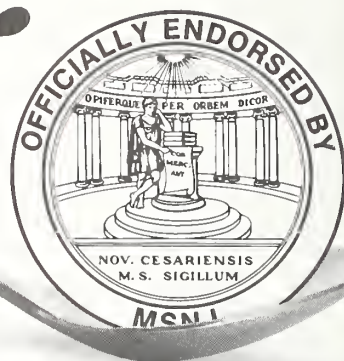
Alternatively, it may be argued that the SEER database is a compilation of many pathologists' diagnoses from all over the country, which may be conducive to many different interpretations and classifications of the four major histologic types.^{8,9} At SBMC, the same, relatively small group of six to eight pathologists on the staff made the histological classifications during the study interval. The interpretation of the histological specimens by a relatively consistent group of pathologists, employing more rigorous cell-differentiation criteria, would lead to greater uniformity in their classification and reduce the variability in the statistical results.

Finally, it has been suggested that smoking is correlated more closely with squamous cell lung carcinoma than with adenocarcinoma of the lung.^{5,7} This correlation, that women are diagnosed with lung cancer at an earlier age than men while smoking for fewer years, is supported by the SBMC data demonstrating the age-at-diagnosis disparity for the squamous cell distribution (Figure 1A) and the absence of the disparity for the adenocarcinoma (Figure 1C).¹ If the current trend continues for younger women to begin smoking, it is to be expected that the difference between male and female age at diagnosis of squamous cell lung cancer will increase. This leads to another concern that needs to be addressed—whether some chemical or hormonal factor of potentially therapeutic value might be identified that has the effect of protecting the male smoker from squamous cell lung cancer for the noted two-to-three-year time interval. ■

REFERENCES

1. McDuffie HH, Klaassen DJ, Dosman JA: Female-male differences in patients with primary lung cancer. *Cancer* 59:1825-1830, 1987.
2. Horn JW, Ardyce JA: Changes in lung cancer mortality among Americans: 1969-1978. *J Natl Cancer Inst* 69:833-837, 1982.
3. Ries LG, Pollack ES, Young JL: Cancer patient survival: Surveillance, epidemiology, and end results program, 1973-1979. *J Natl Cancer Inst* 70:693-706, 1983.
4. Ostle B, Mensing RW: *Statistics in Research*. 3rd Edition. Iowa University Press, 1975.
5. Jett JR, Cortese DA, Fontana RS: Lung cancer: Current concepts and prospects. *CA* 33:74-86, 1983.
6. Kabat GC, Wynder EL: Lung cancer in nonsmokers. *Cancer* 53:1214-1221, 1984.
7. Lubin JH, Blot WJ: Assessment of lung cancer risk factors by histologic category. *J Natl Cancer Inst* 73:383-389, 1984.
8. Dodds L, Davis S, Polossar L: A population-based study of lung cancer incidence trends by histologic type, 1974-1981. *J Natl Cancer Inst* 76:21-29, 1986.
9. Wick MR: Difficulties in the pathologic diagnosis of lung cancer. *Abstract July/August*, 1987.

Your own medicine.



The Exchange is the *only* company providing professional liability insurance that is endorsed and sponsored by the Medical Society of New Jersey.

The Exchange was founded in 1976 by the Society itself because New Jersey physicians urgently needed a secure, stable professional liability program. The commercial carriers had abandoned the State. The Exchange is governed by its insured physicians because a doctor-owned company can best take care of medical professionals' needs.

That's why the Exchange's membership includes more than 7,500 practicing physicians and surgeons in New Jersey... a taste of their own medicine.



**Medical Inter-Insurance
Exchange of New Jersey**

2 PRINCESS ROAD, LAWRENCEVILLE, NEW JERSEY 08648
800-257-6288 609-896-2404

Our Seal of Approval

GERALDINE R. HUTNER, MA

The Medical Society of New Jersey created its own medical seal in an attempt to produce a design that would represent the purpose and function of the organization. Two hundred years later, the seal fortifies the high caliber and faithfulness of the physicians of MSNJ.

It was November 7, 1786. The meeting of the medical men was held at the Sign of the College, Princetown (now Princeton); 22 physicians were present: Moses Bloomfield, William Burnet, Thomas Wiggins, Hezekiah Stites, Clarkson Freeman, Thomas Haight, James Newell, Isaac Harris, Abram Howard, Isaac Smith, Jacob Jennings, Hezekiah Woodruff, John Morris, Henry Blatchley, Ebenezer Blatchley, John Beatty, Elisha Newell, Robert Hendry, Benjamin Tallman, Jonathan Elmer, Benjamin Stockton, and Samuel Kennedy, Jr.

THE NEED FOR A MEDICAL EMBLEM

After discussion on the natural phenomenon of sleep, election of new officers, and review of the Table of Rates and Fees, President Bloomfield "ordered, that a seal be made for the use of this Society, and that Doctor Smith, Doctor Wiggins, and Doctor Beatty be a Committee to procure said seal, and affix what device they think proper."¹ Dr. Isaac Smith (1740-1807) was a distinguished political fig-

ure who joined the Medical Society in 1767. Commissioned a colonel when the war began, Dr. Smith resigned his appointment to become a justice of the New Jersey Supreme Court in 1777. Although he spent the majority of his time in public office, Dr. Smith remained a faithful attendee at MSNJ meetings and served as the Society's fifth president in 1771. Dr. Thomas Wiggins (1731-1832) was a Princeton physician and an original signer of the *Instruments of Association* that formed the Medical Society of New Jersey. The Society's eighth president, Dr. Wiggins was remembered as "a diligent and faithful physician and an elder in the church."² After serving in the war, Dr. John Beatty (1749-1826) settled in Princeton where he enjoyed great success (Figure 1). He later served as president of the Medical Society in 1782 (the 10th president).

Six months later, in May 1787, the next meeting was convened at the hotel of James Drake in New Brunswick. Halfway through the meeting, Dr. Beatty informed the members present that the money deposited for the purpose of procuring a seal for the Society was insufficient, and consequently he could not put the former order in execution.¹ President Burnet ordered that the Committee should continue, with discretionary powers in this business of money,

Ms. Hutner is executive editor, *NEW JERSEY MEDICINE*. Requests for reprints may be addressed to Ms. Hutner, Two Princess Road, Lawrenceville, NJ 08648.

and asked Doctor Scott to become a member of the group. A New Brunswick physician, Dr. Moses Scott (1738-1821) joined the Medical Society in 1782 and served as its president in 1789. Dr. Scott was best known for his services during the war, as he had been present at the battles of Trenton, Princeton, Brandywine, and Germantown.

Members of the Society met again on November 6, 1787, at the house of Colonel Okey Hogland in Burlington. The Committee, under the direction of Doctor Beatty, reported that some progress had been made in designing a seal, but that the business was not yet complete. The President ordered the Committee to continue and requested the members, if possible, to produce the seal by the next meeting. At the meeting of May 6, 1788, in New Brunswick, Dr. Beatty again gave the same report and hoped to procure a seal by the following winter.

However, on November 4, 1788, in Burlington, Doctor Beatty informed the Society that the "expense in procuring a seal would amount to much more than was expected or contributed for, and that the business was not yet completed."¹ The Transactions make no mention of what specific problems had arisen to procuring the seal, but again Doctor Beatty hoped to complete the work by the spring of 1789.

CREATING THE SEAL

It was not until a year later, on November 3, 1789, at the house of Thomas Egbert in New Brunswick, that there was another discussion on the Society's seal. At this meeting, Doctor Beatty produced a seal for the members' approval. He noted, "A press was wanted in order to use the seal of which the Society had just become possessed."¹ Doctor Jacob Dunham was appointed to superintend the production of one that might be proper for the purpose intended.

Dr. Jacob Dunham (1767-1832) practiced in New Brunswick and in the surrounding communities of Bound Brook, Milestone, Washington, Old Bridge, Piscataway, Woodbridge, and Metuchen. Well-known in central New Jersey, Dr. Dunham later helped to organize the Middlesex County Medical Society.

One year later, on November 2, 1790, Doctor Dunham produced the press, "and it was judged well adapted to the purposes intended."¹ The seal was embossed and accepted for Society use. It then was printed on the title pages of the annual Transactions, and used on some presidential papers. However, this first seal did not bear the Society's name (Figure 2).

THE SEAL OF MSNJ

In 1816, the Society was incorporated and the minutes of the February meeting noted that Doctors



Figure 1. Dr. John Beatty was one of the three members who formed the MSNJ Committee to create the seal.

Charles Smith and Augustus Taylor were requested to procure a new seal for the Society. Dr. Smith (1768-1848), a distinguished physician, studied under the well-known Dr. Moses Scott and later married the latter's daughter, Mary. He is remembered as a skillful and successful practitioner and was considered the most scientific and accomplished physician of his day in New Brunswick where he resided.² Dr. Taylor helped to found the Somerset County Medical Society in 1816, and served as its president in 1822. At the June 13, 1816 meeting, an impression of the seal was presented using the original 1790 seal with slight alteration and improvements.

In June 1934, staff members could not find the original artwork for the seal. A new seal was drawn and accepted by the Board in July; this eliminated the dark background and added a white design, thus enhancing its acceptance by making it neater and more legible (Figure 2).

HISTORICAL NOTES

The word seal (from the Latin, *sigillum*) "denote the result of the impact of a hard engraved surface the die or matrix, upon a softer material such as clay or wax, producing a device in relief, the impression. Begun in antiquity, seals were produced in a variety of ways; by the 18th century, seals were in common use by sovereigns, craftsmen, clergy, officials, and tradesmen. According to sigillography (the study of seals), the common materials used at this time included bronze, latten, lead, pewter, or ivory, though gold and silver were used by royal families. Usually the "matrix had one face, and was applied by the

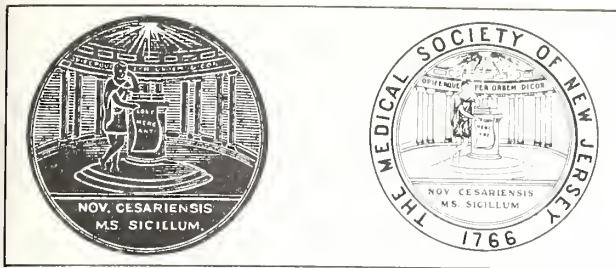


Figure 2. The first seal of the Medical Society of New Jersey, and the present seal.

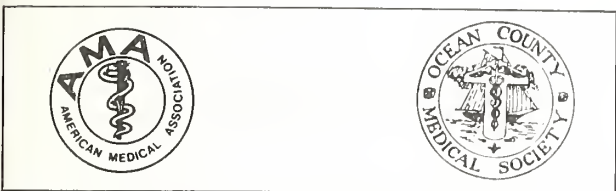


Figure 3. Seal of the American Medical Association and the seal of the Ocean County Medical Society.

means of a handle [on a press], a flange at the back, a ridge with a loop for attachment, or a hexagonal cone surmounted by a pierced trefoil with or without a loop at the top." The most popular shapes were the circular and the oval or pointed oval, which allowed for the design of a figure. The majority of seals had a central figure or device surrounded by an inscription referring to the person or organization. Inscriptions appeared in Latin, but English and French came into use after the 13th century. Abbreviations were common. The word *sigillum* preceded the owner's name, and during the 18th century, Roman capital lettering predominated.³

SYMBOLISM IN THE SEAL

The MSNJ seal (cover) shows the oracle in the Temple of Apollo, the god of health and healing, and the god of the sun. (One of the 12 gods of Olympus, Apollo was known as the classical Greek spirit representing rational and civilized thought.) The High Priest at Delphi is standing at the altar, delivering a prophecy. At the top of the seal is the sun, representing the light of inspiration. Behind the High Priest is an inscription: "Opiferque per orbem dicor"—I am called Help-bringer throughout the world," the words of the Latin poet Ovid from his work, *The Metamorphoses*. On the altar is written, "Cortina merc ant," which is translated, "The tripod of Apollo is opposed to commercialism." The inscription underneath the altar, "Nov. Cesariensis

M.S. Sigillum," is translated, "The Seal of the Medical Society of New Jersey."

As noted by historian Dr. Fred Rogers, the seal, "while attractive from an artistic standpoint, its inherent beauty is that it exemplifies the idealism of the founders of our medical society. A symbol which links the present with the past, it also conveys to the future, the aims of the medical profession and of a pioneer medical organization."

OTHER MEDICAL EMBLEMS

The medical profession, in general, is associated with two additional seals. The first seal is associated with the Greek god of medicine and healing, Aesculapius. Son of Apollo, he is known for his serpent, usually twined around a staff, the traditional symbol of healing. In addition, Aesculapius is associated with a cock, symbolizing medicine, healing, and rejuvenation. Tradition notes that the sacrifice at a god's shrine was a cock; temple priests of Aesculapius used the sex organs of castrated cocks as hormonal medicine. Hygeia, goddess of health, and Panacea, healer of the sick, were the daughters of Aesculapius; his sons, Podalirius and Machaon, also became physicians.⁵ Mythology notes that Hygeia, Panacea, and Podalirius were ancestors of Hippocrates, the father of medicine. The Hippocratic oath, taken by every physician, begins with the words, "I swear by Apollo, the physician."

The official seal of the American Medical Association (Figure 3) features the single snake entwined around the knotty staff of Aesculapius. The symbolism of this staff concerns the problems of medicine, and the snake symbolizes the renewal of life itself by sloughing off its skin periodically.⁵

The second seal style is associated with the Latin god, Mercury (Greek god, Hermes), known for reason and eloquence; he carried the caduceus, "magic wand," with two intertwining snakes. It is thought that the caduceus may originally have been an olive branch which then was tipped with a circle and a crescent—and still later assumed the formation of the entwined snakes. Mythology notes that Mercury threw his magic wand at the two fighting snakes which then became affixed to it. Although the snakes symbolize fertility, wisdom, and the power to heal, it is the knotty staff with a single snake rather than the caduceus with the two snakes which remains the symbol of the art of medicine. ■

REFERENCES

1. Rise, Minutes, and Transactions of the New Jersey Medical Society. Newark, NJ, Jennings and Hardham, 1875. Pp. 51, 53, 67, 75, 92.
2. Wickes S: *History of Medicine in New Jersey and of its Medical Men*. Newark, NJ, Martin R. Dennis & Co., 1879. Pp. 434, 399.
3. *Encyclopedia Britannica*, 1986, pp. 125-129.
4. Rogers FB, Sayre AR: *The Healing Art*. Trenton, NJ, Medical Society of New Jersey, 1966.
4. One Snake or Two? *AMA News* 3:1, 1960.
5. Laughlin VC: The Aesculapian staff and the caduceus as medical symbols. *J Intern Coll Surg* 38:82-92, 1962.

Euthyroid Hypertri-iodothyronemia

MICHAEL H. GOLDMAN, MD
DARIUS S. SYPEK, MD

The authors present a patient with an autonomously functioning thyroid nodule and a persistently elevated tri-iodothyronine level. Clinical euthyroidism along with a normal thyroxine level and a normal response to thyroid-releasing hormone could represent a rare state of euthyroid hypertri-iodothyronemia.

The diagnosis of clinical hyperthyroidism usually is confirmed by an elevated thyroxine (T_4) level. Occasionally, tri-iodothyronine (T_3) toxicosis can be seen with normal T_4 levels.¹ This occurs especially in patients with nodular thyroid disease.² In either case, the thyroid-stimulating hormone (TSH) response to the

thyrotropin-releasing hormone (TRH) is absent or blunted, confirming a thyrotoxic state.

Elevated T_4 levels also can be seen in nontoxic states, a condition called euthyroid hyperthyroxinemia.³ In this condition, although the measured T_4 levels exceed the normal range, the T_3 radioimmunoassay (RIA) levels may be normal or elevated, the TRH stimulation tests are normal. This disorder may be caused by acquired or inherited abnormalities of the protein binding, acute medical or psychiatric illnesses, peripheral resistance to thyroid hormones, or, possibly, drug-related effects.

Dr. Goldman is an attending, Section of Endocrinology, and Dr. Sypek is a chief resident, Department of Internal Medicine, Englewood Hospital, Englewood. Requests for reprints may be addressed to Dr. Goldman, Department of Medicine, Englewood Hospital, 350 Engle Street, Englewood, NJ 07631.

CASE REPORT

We report a case of a clinically euthyroid patient with an autonomously functioning thyroid nodule (AFTN) having elevated T_3 levels (total and free) with normal T_4 levels and a normal TRH stimulation test. This condition may be called euthyroid hypertri-iodothyronemia.

CASE REPORT

A 25-year-old female was referred for evaluation because of an abnormal thyroid ultrasound. A solid 2.8 x 2.3 cm nodule with evidence of calcifications and central cystic degeneration was reported in the left lower pole. A 5 mm cyst also was found in the right lobe.

Thyroid function tests including a thyroxine (T_4) level, T_3 resin uptake (T_3 RU), and a thyroid-stimulating hormone (TSH) level reportedly were normal.

Prior thyroid history was notable for the presence of a nodule since 1980, but the details were not remembered by the patient. No history of radiation exposure could be elicited.

Physical examination showed a clinically euthyroid patient with a nodule in the left lower pole of the thyroid gland. No nodules were felt on the right.

Fine-needle aspiration revealed groups of mildly atypical follicular thyroid cells with a few white blood cells.

The patient was started on levothyroxine suppression therapy at the dose of 0.125 mg/day. Prior medical records received one month later revealed that in 1980 the patient was diagnosed to have a hot thyroid nodule in the left lower pole, autonomous in nature. Initial Iodine¹²³ uptake at that time was elevated to 33.5 percent at six hours (normal range not reported) and decreased to only 22 percent following 75 mg of tri-iodothyronine (T_3 , Cytomel® administered for ten days).

Also, normal T_4 , T_3 RU, and TSH levels were reported at 8.0 μ g/dL, 37 percent, and 2 μ U/mL, respectively (normal ranges 5.5 to 11.5 μ g/dL, 35 to 45 percent, and <7 μ U/mL). A high normal T_3 RIA level was measured at 186 ng/dL (normal 100 to 190

ng/dL). In 1984, a routine examination showed a 1.5 cm thyroid nodule on the left, again with normal T_4 , T_3 RU, and TSH. No T_3 RIA was reported.

After reviewing this information and finding elevated T_4 and T_3 RIA levels on repeat testing one month after the initial consultation (16.0 μ g/dL and 212 ng/dL, respectively), levothyroxine (Synthroid®) was stopped. Two months later, T_4 was normal at 8.8 μ g/dL but T_3 RIA increased further to 274 ng/dL. Repeat levels one month later showed a T_4 of 9.0 μ g/dL and a T_3 RIA of 293 ng/dL. Free T_3 level was found to be elevated at 7.1 pmol/L (normal range 2.1 to 6.3 pmol/L).

A baseline TSH level measured with the new sensitive assay was low, but nonsuppressed at 0.3 μ U/mL (normal range 0.5-3.0 μ U/mL).⁴ The patient underwent a thyrotropin-releasing hormone (TRH) stimulation test which showed a TSH response to 8.7 μ U/mL (normal response is indicated by a rise in TSH level to greater than 2.0 μ U/mL).

A thyroid scan performed one month later revealed a slightly elevated radioactive iodine¹²³ uptake of 15.7 percent at six hours (normal 5 to 15 percent) and a hot nodule in the left lower pole with only a faint outline of the gland on the right side.

DISCUSSION

The simultaneous occurrence of an elevated T_3 RIA level and a normal TRH stimulation test suggests a state of hormonal balance somewhere between normalcy and T_3 toxicosis.

The patient repeatedly had elevated total and free T_3 RIA determinations. Also, a nonsuppressible solitary thyroid nodule with an elevated radioiodine uptake was demonstrated. Despite the laboratory abnormalities consistent with a hypertri-iodothyronemic state, she was not clinically thyrotoxic; she showed a subnormal but not severely suppressed TSH level as measured by the new sensitive assay, and had a normal TSH response to the TRH stimulation. Other methods of determining excessive peripheral thyroid hormone activity include: shortened systolic time intervals, elevated basal metabolic rate, elevated glutathione S-transferase activity, reduced serum creatine kinase activity, reduced serum cholesterol levels, and occasionally decreased bone density. However, these rarely are used because they are cumbersome and lack sensitivity and specificity.

AFTN, such as the one found in this patient, are characterized by the failure to significantly decrease their uptake of radioactive iodine following suppressive doses of thyroid hormone, as well as by their ability to suppress the function of the otherwise normal surrounding thyroid parenchyma.⁵

These nodules can be toxic or nontoxic in nature.⁶ Toxic nodules, less common than the nontoxic ones, can secrete an excess of T_4 and/or T_3 . The condition

Euthyroid hyperthyroxinemia. Nontoxic state where T_4 RIA levels are normal or elevated and TRH stimulation tests are normal. May be caused by acquired or inherited abnormalities of the protein binding, acute medical or psychiatric illnesses, peripheral resistance to thyroid hormones, or drug-related effects.

Table. Abbreviations.

TSH =	Thyroid-stimulating hormone
TRH =	Thyrotropin-releasing hormone
AFTN =	Autonomously functioning thyroid nodule
RIA =	Radioimmunoassay
RU =	Resin uptake
RAI =	Radioactive iodine

where only T_3 is elevated is known as T_3 toxicosis.² In this setting, clinically hyperthyroid patients have elevated T_3 levels, normal T_4 levels, and a blunted TSH response to the TRH stimulation.

Patients having similar laboratory findings also may appear clinically euthyroid. This condition has been referred to as "subclinical hyperthyroidism" and patients have been followed conservatively over a number of years.⁷

Clinically euthyroid patients with AFTN having normal T_3 and T_4 levels may have a blunted TRH response which, according to one author, may represent a transitional phase from the nontoxic to the toxic state.⁵

Interestingly, in a study of AFTN in clinically euthyroid adolescents, one out of seven patients was found to have an elevated T_3 RIA, a normal T_4 , and a normal TRH test ($12 \mu\text{U/mL}$; normal response to 10 to 21 $\mu\text{U/mL}$)—a situation analogous to that of our patient.⁸

The authors could not explain this apparently discrepant finding. This condition could be called euthyroid hypertri-iodothyronemia and could represent yet another transitional phase in the evolution of the AFTN.

It is difficult to explain why some patients with normal thyroid function tests may have blunted TRH responses while others, like our own, may have elevated T_3 RIA levels with normal TRH responses.

Perhaps in certain individuals, the pituitary is less sensitive to the feedback inhibition from the circulating-thyroid hormones. It has been shown that the TRH-induced TSH release may be exquisitely sensitive to inhibition by supplemental quantities of T_3 and T_4 which do not raise serum T_3 and T_4 levels above normal.⁹ On the other hand, our patient's "transitional phase" hormonal profile may be explained by the relative insensitivity of the pituitary to the mild T_3 elevation. It has been shown that T_4 is a more important suppressant of TSH secretion than T_3 , via a mechanism involving intrapituitary conversion of T_4 to T_3 .¹⁰

The clinical significance of an isolated T_3 elevation also is unclear. This situation could raise concerns similar to those in patients on thyroid hormone replacement with isolated T_4 elevations who are felt to be at possible risk for osteoporosis and other end organ abnormalities.¹¹ This concern has obvious implications for our therapeutic approach to these patients and needs to be investigated further.

SUMMARY

We presented a clinically euthyroid patient with an autonomously functioning thyroid nodule (AFTN), elevated total and free T_3 levels, normal T_4 level, and a normal TRH stimulation test. This condition may be called euthyroid hypertri-iodothyronemia. ■

REFERENCES

- Hollander CS, Nihei N, Burday SZ, et al.: Clinical and laboratory observations in cases of tri-iodothyronine toxicosis confirmed by radioimmunoassay. *Lancet* 1:609-611, 1972.
- Hamburger JI: Evolution of toxicity in solitary nontoxic autonomously functioning thyroid nodules. *J Clin Endocrinol Metab* 50:1089-1093, 1980.
- Borst GC, Eil C, Burman KD: Euthyroid hyperthyroxinemia. *Ann Intern Med* 98:366-378, 1983.
- Klee GG, May ID: Sensitive thyrotropin assays: Analytic and clinical performance criteria. *Mayo Clin Proc* 63:1123-1132, 1988.
- Hurley JR, Becker DV: Thyroid suppression and stimulation testing: The place of scanning in the evaluation of nodular thyroid disease. *Semin Nucl Med* 11:149-160, 1981.
- Hamburger JI: The autonomously functioning thyroid nodule: Goetsch's disease. *Endocr Rev* 8:439-447, 1987.
- Evered DC, Clark F, Petersen VB: Thyroid function in euthyroid subjects with autonomous thyroid nodule. *Clin Endocrinol* 3:149-154, 1974.
- Osburne RC, Goren EN, Bybee DE, Johnsonbaug RE: Autonomous thyroid nodules in adolescents: Clinical characteristics and results of TRH testing. *J Pediatr* 100:383-386, 1982.
- Snyder PJ, Utiger RD: Inhibition of thyrotropin response to thyrotropin-releasing hormone by small quantities of thyroid hormones. *J Clin Invest* 51:2077-2081, 1972.
- Larsen RP, Silva EJ, Kaplan MM: Relationship between circulating and intracellular thyroid hormone. Physiological and clinical implications. *Endocrinol Rev* 2:87-102, 1981.
- Ross DS: Subclinical hyperthyroidism: Possible danger of overzealous thyroxine replacement therapy. *Mayo Clin Proc* 63:1223-1229, 1988.

Epidemiology of Congenital Syphilis

MICHAEL E. PETRONE, MD, MPH

MARY J. TETER, DO

CLIFFORD G. FREUND, MPH

JOHN PORTER, MBBS, MPH

WILLIAM E. PARKIN, DVM, DrPH

KENNETH C. SPITALNY, MD

Between 1984 and 1987, the number of reported cases of congenital syphilis in New Jersey tripled. Findings indicate an increase in early syphilis among females of childbearing age living in areas of high syphilis morbidity, reflecting, possibly, lifestyle changes within populations already at risk for the disease. Future studies and interventions are needed.

Congenital syphilis is one of the most unfortunate consequences of untreated infectious syphilis during pregnancy. Recent reports state syphilis causes fetal or perinatal death in approximately 40 percent of the infants affected.¹ Following years of gradual decline, we now are seeing a nationwide resurgence of congenital syphilis. Increases in reported cases of congenital syphilis generally reflect the incidence of primary and secondary syphilis among women of childbearing age during

the previous year.² Like the rest of the nation, New Jersey is experiencing an increase in the number of cases of syphilis in females and in the reported number of cases of congenital syphilis. From 1977 to 1985, the number of congenital syphilis cases in New Jersey remained fairly constant (less than four cases per year), except for six cases reported in 1983. However, in 1986 and 1987, there was a resurgence of cases which led to concerns that the epidemiology of congenital syphilis might be changing. Further analysis revealed that between January 1984 and December 1987, the number of reported cases of congenital syphilis in New Jersey more than tripled from three to ten cases per year (Figure).

This information is of particular public health sig-

From the Division of Epidemiology and Disease Control, New Jersey State Department of Health. Requests for reprints may be addressed to Dr. Petrone, NJDOH, Division of Epidemiology and Disease Control, CN 369, Trenton, NJ 08625-0369.

Table 1. Criteria for the diagnosis of congenital syphilis.

Definite Case

Identification of *T. pallidum* darkfield microscopy, fluorescent antibody, or other specific stains in specimens from lesions, autopsy material, placenta, or umbilical cord.

Probable

- Reactive serologic test for syphilis in a stillborn
- + VDRL in CSF
- + Serologic test for syphilis with systematic manifestations
- Fourfold rise in VDRL or rapid plasma reagin and + FTA-ABS or MHA-TP
- Persistent reactive treponemal test for six months

VDRL—Venereal disease research laboratory test

FTA-ABS—Fluorescent treponemal antibody—absorption test

MHA-TP—Microhemagglutination assay for antibody to *T. pallidum*

nificance for two reasons: 1. Congenital syphilis is preventable by adequate and timely treatment of the mother. 2. This increase is occurring in the era of AIDS, in which a major effort is being made to reduce high-risk behavior.

We have examined the changing trend of reported cases of congenital syphilis in New Jersey. In 1988 a descriptive epidemiological study was conducted to examine the characteristics of 26 cases of congenital syphilis which had been reported between 1984 and 1987. Specifically, an attempt was made to determine contributing risk factors that permit mothers to deliver children with congenital syphilis and to develop hypotheses as to why this increase is occurring.

METHODS

Incidence rates of primary and secondary syphilis in women in New Jersey from 1984 to 1987 were compared to the rates of congenital syphilis infections over this period. Information pertaining to all

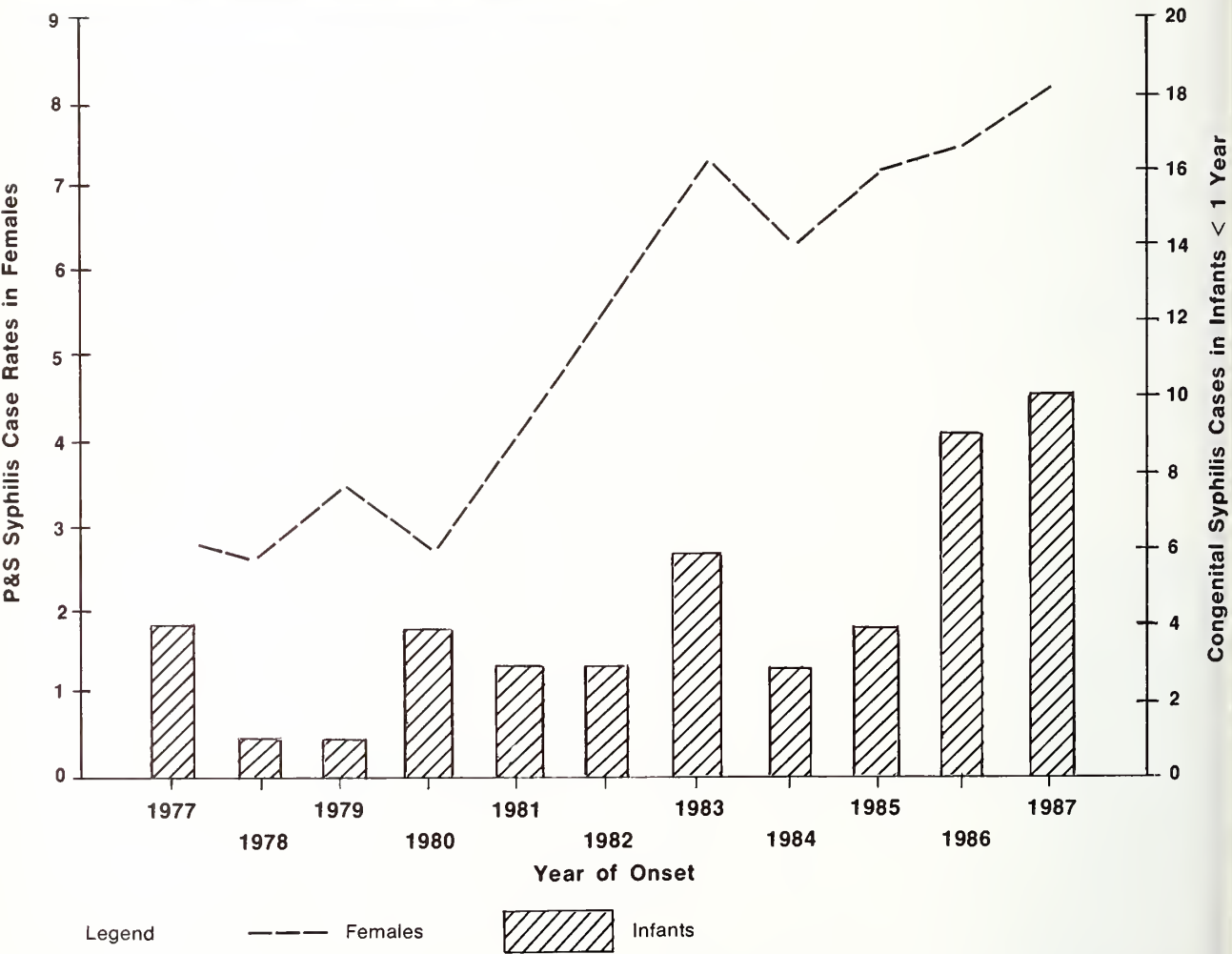


Figure. Primary and secondary syphilis case rates in females and congenital syphilis cases in infants less than one year of age in New Jersey, 1977 to 1987.

Table 2. Primary and secondary female syphilis cases and percent change, 1984 to 1987. Number and rates per 100,000 estimated population.

	1984	1985	1986	1987	Total % Change
Cases	242	279	287	318	+31.4
Rate	6.3	7.3	7.5	8.3	+31.7
Percent		+15.8	+2.7	+10.6	

	1984	1985	1986	1987	Total % Change
Cases	3	4	9	10	+233.3
Rate	2.9	3.8	8.3	9.2	+217.2
Rate Percent Change		+31.0	+118.4	+10.8	

Table 3. Frequency of clinical signs among infants with reported congenital syphilis, 1984 to 1987.

Category	Cases
Diagnostic	
Definite case	6 (23%)
Probable case	20 (77%)
Symptoms case	13 (50%)
No symptoms case	10 (38%)
Undetermined	3 (12%)
Clinical (some infants presented more than one symptom)	
Hepatosplenomegaly	6
Jaundice	2
Rash	2
Snuffles	1
Laboratory	
Serologic test for syphilis	7 (27%)
Osteochondritis	7 (27%)

Table 4. Selected maternal characteristics of congenital syphilis births, 1984 to 1987.

Mothers (n=25)	
Age (mean)	21 years
Race	
Black	20 (80%)
Hispanic	4 (16%)
White	1 (4%)
Marital Status	
Single	20 (80%)
Married	1 (4%)
Divorced	1 (4%)
Undetermined	3 (12%)
Geographic Areas	
Urban	19 (76%)
Other	6 (24%)

congenitally infected infants born in New Jersey between January 1984 and December 1987 and their mothers was abstracted from the Centers for Disease Control congenital syphilis followup forms and primary and secondary syphilis report forms. Factors investigated in the mothers of infants with congenital syphilis were age, race, clinical history, prenatal care and treatment, and geographic distribution. Infant cases were compared relative to clinical and serological variables reported at the time of delivery.

A questionnaire was sent to 80 obstetric hospitals in 1986 to determine routine screening policies for syphilis during pregnancy. The data were collected relative to recent changes in policy, type of screening, and time of screening during pregnancy.

Criteria for diagnosis of congenital syphilis in New Jersey were taken from standards developed by Kaufman et al.³ on which data were available as definite, probable, possible, or unlikely cases. In New Jersey, only definite and probable cases counted as meeting the case definition (Table 1).

RESULTS

A review of congenital syphilis cases revealed that 26 cases were identified based on the case-definition between 1984 and 1987. Twenty-four cases were single deliveries and one case was a twin delivery. Six cases (23 percent) were definite and 20 cases (77 percent) were probable. When compared with primary and secondary syphilis case rates for the previous year, we found rates for congenital syphilis to be much higher, suggesting that the incidence of primary and secondary syphilis alone does not ex-

Table 5. High syphilis morbidity areas and reported number of congenital syphilis (CS) cases, 1984 to 1987.*

County	Primary & Secondary Syphilis Cases	Percent	Congenital Syphilis Cases	Percent
Atlantic	151	5.0	3	11.5
Camden	86	3.0	4	15.7
Essex	1140	40.0	3	11.5
Hudson	444	16.0	3	11.5
Mercer	133	5.0	3	11.5
Passaic	250	9.0	3	11.5
Total	2204	78.0	19	73.2
Total New Jersey	2857	100.0	26	100.0

*Areas with reported annual incidence rates of primary and secondary syphilis > 7.0/100,000 persons.^a

Table 6. Clinical factors associated with mothers of 26 infants with congenital syphilis, 1984 to 1987.

Factor	Number of Mothers (n=25*)
Mother did receive prenatal care	15 (60%)
Trimester seen	
1st only	4 (27%)
2nd only	2 (13%)
1st and 3rd	5 (33%)
3rd only	4 (27%)
Failure by facility to appropriately screen or treat for syphilis ¹	9 (60%)
Mother did not receive prenatal care	10 (40%)

*One woman had delivered twins.

plain the increase of congenital syphilis over this period (Table 2). Symptoms were reported in 50 percent of the infants, while 10 infants (38 percent) were asymptomatic. Symptom histories were not available for 3 infants (12 percent). Some infants presented with more than one symptom. Osteochondritis was the most prevalent symptom appearing in 7 infants (27 percent) (Table 3).

Information on the mothers of these infants revealed that the typical mother was young, single, black, or Hispanic, and lived in urban areas having an increased incidence of primary and secondary syphilis. The mean age of mothers was 21 years (range 15 to 29 years); 20 women (80 percent) were black, 4 women (16 percent) were Hispanic, and 1 woman (4 percent) was a white non-Hispanic. Twenty women (80 percent) were single (unmarried), 1

woman (4 percent) was married, and 1 woman (percent) was divorced. Information was not available for 3 mothers. Nineteen mothers lived in urban areas (Table 4). Of the 26 reported cases, 19 cases (73 percent) were from urban areas which account for nearly 80 percent of the reported infectious syphilis cases in the state (Table 5).

A review of the prenatal care data indicated that 15 mothers (60 percent) received some prenatal care while 10 mothers (40 percent) received no care. In addition, 10 mothers (40 percent) presented only once for prenatal care. Of those 15 women seen for prenatal care, 9 women (60 percent) either were not appropriately screened or, if found to be positive were not treated for syphilis (Table 6).

Of the 80 maternity hospitals surveyed for information on their routine syphilis screening policy during pregnancy, 67 hospitals (84 percent) responded to the questionnaire. Fifty-three hospitals (79 percent) reported some form of screening, 37 hospitals (55 percent) reported routine screening of all pregnant women, and 16 hospitals (24 percent) reported screening high-risk groups only. Of the 37 hospitals performing routine screening, only 9 hospitals (24 percent) required screening during both the first and third trimesters.

In addition, of the 67 hospitals responding to the survey, 24 hospitals (36 percent) were located in high-risk areas and all reported performing a screening test for syphilis during pregnancy. These hospitals tended to have better screening practices than the suburban or rural hospitals, and 9 of the 24 hospitals (38 percent) reported screening during both the first and third trimesters (Table 7). In general, hospitals reported no change in their routine screening policy for syphilis during pregnancy over the period studied.

As a result of the hospital survey, in October 1986 the New Jersey Department of Health issued

Table 7. Survey of hospital screening congenital syphilis, 1986.

Hospitals (n=80)	
Hospitals responding to questionnaire	67 (84%)
Routine screening	37 (55%)
Trimester	
1st only	24 (65%)
1st and 2nd	3 (8%)
1st and 3rd	9 (24%)
3rd only	1 (3%)
Screen high risk only	16 (24%)
Some screening (total)	53 (79%)
Insufficient information	14 (21%)
Hospitals responding to questionnaire (Total)	67 (84%)
Geographic areas	
Inner city (high risk)	24 (36%)
Screening	
1st and 3rd	9 (38%)
Suburban	43 (64%)
Screening	
1st and 3rd	0

health bulletin addressing the problem of increasing numbers of congenital syphilis cases in the state. It was recommended that all prenatal health care facilities adopt a policy of testing high-risk prenatal patients for syphilis during both the first and third trimesters of pregnancy and at the time of delivery.

DISCUSSION

Our findings support the hypothesis that "new" causative factors among those populations at risk for sexually transmitted diseases (STDs) may be involved in the increased occurrence of congenital syphilis among infants in New Jersey.

In recent years, high-risk factors identified for early congenital syphilis in the United States were inadequate prenatal care and ethnic origin.⁴ It has been suggested that perhaps the higher incidence of congenital syphilis in American blacks and Hispanics is a consequence of inadequate prenatal care in these socially disadvantaged groups.⁵ Data for

New Jersey are consistent with this finding. The typical mother who delivered an infant with congenital syphilis was young, single, black, or Hispanic, lived in an area of high syphilis morbidity, and received inadequate prenatal care. However, our data indicate no change in the quality or delivery of prenatal health care to these high-risk groups during this period suggesting that the cause for the increased incidence of congenital syphilis infections in this population may be independent of the services provided in the existing health care system. To date, there are few published data on the extent to which lifestyle changes may affect the occurrence of disease among these socially disadvantaged groups. Studies^{6,7} have identified drug users among those populations at risk for transmission of STDs through the exchange of sex for drugs. As a result of their addiction to drugs, women have intercourse with drug dealers in exchange for cocaine, crack, and other drugs. The drug suppliers, often users of intravenous drugs themselves, may be the source for the transmission of syphilis and other STDs through "unsafe" sex practices. The impact of this new phenomenon on a variety of public health problems is not readily understood since this group often is outside the health care systems administered by local health departments (STDs clinics). This new problem needs further investigation so that effective public health intervention strategies targeted toward these high-risk populations can be developed.

We recognize the limitations of this study and the inferences drawn from the data. First, the results are based on a relatively small number of cases; some bias is associated with the reporting of these cases. However, we believe our findings are significant in that they help to describe the changing epidemiology of congenital syphilis in our state and establish a basis from which we can target future intervention strategies.

Additional research studies are needed to further define the risk characteristics of mothers of infants with congenital syphilis and to target public health intervention activities to reach these high-risk populations who do not regularly access traditional health care systems. ■

REFERENCES

1. Centers for Disease Control: Guidelines for the prevention and control of congenital syphilis. *MMWR Supplement* 37:1-13, 1988.
2. Centers for Disease Control: Congenital syphilis—United States, 1983-1985. *MMWR* 35:625-628, 1986.
3. Kaufman RE, Jones OG, Blount JH: Reported early congenital syphilis problems in diagnosis and treatment. *J Am Ven Dis Assoc* 4:135-139, 1977.
4. Mascola L, Pelosi R, Blount JH, et al.: Congenital syphilis: Why is it still occurring? *JAMA* 252:1719-1722, 1984.
5. Ewing CI, Roberts C, Davidson DC, Arya OP: Early congenital syphilis still occurs. *Arch Dis Child* 60:1128-1133, 1985.
6. Centers for Disease Control: Acquired immunodeficiency syndrome (AIDS) among blacks and Hispanics—United States. *MMWR* 35:655-656, 1986.
7. Bakeman R, Lumb JR, Jackson, RE, Smith DW: AIDS risk-group profiles in whites and members of minority groups. *N Engl J Med* 315:191-192, 1986.
8. Centers for Disease Control: Sexually transmitted disease statistics, December 1985.

Physician Service to Afghan Refugees

New Jersey physicians have been giving their expertise and invaluable skills to aid Afghan war victims. MSNJ members are responding with compassion and concern to this crisis.

RoseMarie Peterkin, chairwoman of the Afghan Refugee Assistance Fund, stated "Members of the Medical Society of New Jersey have been freely giving their expertise and invaluable skills to aid Afghan war victims. Our New Jersey doctors respond immediately with compassion and concern whenever we request their urgent and life-restoring service. They are a testimony to the giving and caring membership of the medical profession. Drs. Richard J. D'Amico, Herbert L. Glatt, Andrew C. Lipka, Jeffrey L. Lipkowitz, Peter Lipron, Stephen LoVerme, and Leon I. Small, and Holy Name Hospital, Kessler Memorial Hospital, The Medical Center at Princeton, and Montclair Community Hospital already have given their services to help the refugees."

For information on the Afghan Refugee Assistance Fund call, 201/325-0634.



Figure 1. Mickey Mouse visits Nur Allah and his friend after successful surgery by Dr. D'Amico at Holy Name Hospital.

The Afghan Refugee Assistance Fund (ARAF) is growing. Since January 1988 when ARAF first assisted Senator Lautenberg's office to find housing for an Afghan being treated at St. Joseph's Hospital and Medical Center, Paterson, 11 refugees have been able to receive medical care that would not be available to them in Pakistan.

Dr. Peter Lipron, a neurosurgeon from Absecon, and Kessler Memorial Hospital, Hammonton, generously donated services to two freedom fighters whose constant head pain could only be more accurately treated through medical equipment that is nonexistent in Peshawar, but is a standard tool in most New Jersey hospitals.

Last January, two young Afghan boys, selected through the International Medical Corps, and flown via the auspices of the Intergovernmental Committee of Migration, began medical treatment for their war-sustained injuries in New Jersey. Ten-year-old Nur Allah suffered a shot through his skull and developed severe weakness and lack of muscular coordination of his right side, and paralysis of his right arm and hand. Nur Allah's long road to recovery began with a kind smile and a discerning examination by Dr. Richard D'Amico, an Englewood plastic surgeon. Dr. D'Amico ordered initial physical therapy before surgery could be performed. After a month of intense exercises, Dr. D'Amico and his team at Holy Name Hospital, Teaneck, performed extensive surgery to reconstruct Nur's right arm with multiple tendon transfers and tendon lengthenings, so that Nur would have some use of this arm and hand. Not only did Dr. D'Amico and his wonderful staff donate all services, but Holy Name Hospital and its excellent nurses and staff did also.

While Nur was healing (Figure 1), his father, Quramban, related to Dr. D'Amico he had pain in his leg and chest. This fine surgeon instinctively

knew this Afghan suffered severe physical damage due to the war. Shortly after Nur was released from Holy Name Hospital, Dr. D'Amico removed shrapnel and scar tissue from Quramban's chest and left leg.

Juma Din Khan, 13, was blinded by a "toylike" bomb; he lost vision in both eyes when he picked up a booby-trapped weapon designed to look like a toy.

Juma Din Khan received his sight-restoring eye care (Figure 2) through the generous and expert service of Dr. Andrew Lipka, an ophthalmologic surgeon and Dr. Jeffrey Lipkowitz, a retina specialist, both of Princeton.

Juma Din no longer has to be led around by the hand; he can count fingers, and soon will be able to read. This medical miracle occurred due to the skills and expertise that these doctors freely gave to Juma Din. During a three-hour operation at The Medical Center at Princeton, which also donated its service, Juma Din received the corneal transplant which restored his vision.

Another child, Ali Fardin, arrived to New Jersey for similar eye treatment, but due to the great delay in reaching medical care, the sight in his right eye cannot be restored. Dr. Herbert Glatt, eye surgeon from Bloomfield, generously is donating services to this 12-year-old victim. Ali's right eye was punctured by shrapnel when a Soviet bombing raid destroyed his home. Due to lack of microsurgical equipment, the eye degenerated to such a point where it could not be helped. Mr. Schreiber, an ocularist from Newark, is fitting Ali with a sometic device, as Dr. Glatt continues his care.

The youngest child to be helped is four-year-old Masuma. She suffered severe and extensive burns when her family was caught in a Soviet bombing raid, 18 months ago. Six family members were killed, but Masuma and her father escaped. They arrived in New Jersey to receive expert and necessary care.

Dr. Stephen LoVerme, a reconstructive plastic surgeon and hand specialist from Bloomfield, will perform surgery to attempt to restore some use of a tiny left hand where four fingers have been melted beyond recognition. Montclair Community Hospital has generously donated its facilities, and Dr. Leon Small, a pediatrician from West Orange, also has agreed to help this tiny war victim.

This is a story of two kinds of heroes: the doctors who selflessly give their health restoring service freely, and the victims of a brutal struggle. Afghanistan has five million refugees, the largest refugee population in the world. In Afghanistan, there are only 200 doctors to aid 15 million Afghans. If there are other doctors who wish to assist these war victims, please call 201/325-0634. ■

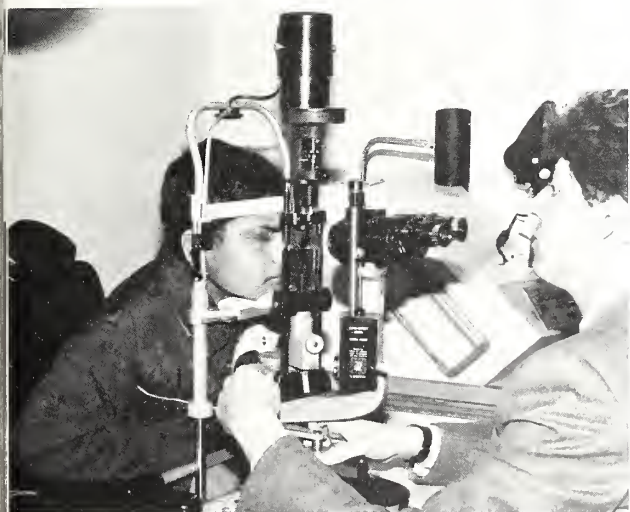


Figure 2. Juma Din Khan gets a checkup after his sight-restoring operation at The Medical Center at Princeton; his physicians were Drs. Lipka and Lipkowitz.

MSNJ LIAISON REPRESENTATIVES

Academy of Medicine of New Jersey

(1) Board of Trustees/Liaison Committee
(Liaison requested by Academy—June 19, 1966)

Sherman Garrison, MD Bridgeton
Bernard Robins, MD Union
Edwin W. Messey, MD Willingboro

(2) Postgraduate Medical Education Study Committee
(Representation requested by Academy—November 15, 1964)

Bernardo Toro-Echague, MD Plainfield
David E. Swee, MD New Brunswick

**AIDS Education and Training Center (RAETC), State-
wide Advisory Committee to New Jersey Regional**
(Representation requested by UMDNJ—July 6, 1989)

To be designated

AMA-Education Research Foundation

(Liaison requested by AMA—October 7, 1951)

David J. Greifinger, MD Belleville

Archivist-Historian

(Appointment requested by the Medical History Society
of New Jersey—April 1982)

Morris H. Saffron, MD New York, NY

Audit Review Committee

(Appointed annually to review previous year's audit)

Joel S. Cherashore, MD, *Chairman* Nutley
Palma E. Formica, MD Old Bridge
Edwin W. Messey, MD Willingboro
Fred M. Palace, MD Morristown
Gerald H. Rozan, MD, *Consultant* Wayne
Matis A. Fermaglich, MD, *Consultant* Teaneck
Angelo S. Agro, MD, *Consultant* Haddonfield
Michael M. Heeg, MD, *Consultant* Trenton

Blindness—New Jersey, National Society To Prevent
(Requested by the National Society To Prevent Blind-
ness—New Jersey—March 19, 1978)

Alfonse A. Cinotti, MD Jersey City

Blood Bank Association, New Jersey

(Liaison requested by New Jersey Blood Bank Associa-
tion—April 25, 1969)

Frank Campo, MD Trenton

Blood Banking Task Force for New Jersey

(UMDNJ—October 1981)

Frank Campo, MD Trenton

Dental Health, State Task Force for Better

(Representation requested by Department of Health—
January 30, 1985)

Glenn P. Lambert, MD Flemington

Diabetes Coordinating Council

(Representation requested by Department of Health—
November 10, 1980)

Arthur Krosnick, MD Princeton

Drug and Alcohol Problems, Statewide Committee To Assist Local School Districts with

(Representation requested by Department of Education
Regional Curriculum Services Unit—South—June 5, 1984)

Ed Reading, MDiv Lawrenceville

Drug Utilization Review Council, New Jersey

(Representation requested by Department of Health—
December 19, 1984)

Harry M. Woske, MD Flemington

Education, State Department of

(Liaison requested by the Assistant Commissioner of
Education—September 21, 1958)

Glenn P. Lambert, MD Flemington

Emergency Medical Personnel and Hospitals, Division on Women, Training Program for

(Representation requested by the Department of Com-
munity Affairs, Division on Women—August 2, 1984)

Rudolf E. Schwaeble, MD Mendham

Environmental Education, Commission on

(MSNJ requested to nominate a physician to serve—
August 2, 1989)

Glenn P. Lambert, MD Flemington
(pending)

Executive Committee

(Provided in the Bylaws, Chapter III (c))

Paul J. Hirsch, MD,
Chairman, President Bridgewater
Douglas M. Costabile, MD,
President-Elect Murray Hill
Joseph A. Riggs, MD,
First Vice-President Haddonfield
William E. Ryan, MD,
Second Vice-President Pennington
Palma E. Formica, MD,
Immediate Past-President Old Bridge
Bernard Robins, MD, *Secretary* Union
Gerald H. Rozan, MD, *Treasurer* Wayne

Graduate Medical Education, Advisory Council on
(Representation requested by UMDNJ—1979)

Stephen F. Wang, MD Morristown

Health Care Administration Board
(MSNJ staff representation—July 1983)

A. Ronald Rouse Lawrenceville

Health Maintenance Organization Projects, Advisory Committee To Participate in the Review of
(Recommended to executive director, Statewide Health Coordinating Council, Department of Health—1974)

Henry J. Mineur, MD Westfield

Hospital Association, New Jersey

(Liaison established at request of New Jersey Hospital Association—December 17, 1967)

Palma E. Formica, MD Old Bridge

Hospital Medical Staff Section, Governing Council
(Hospital Medical Staff Section established by 1984 House of Delegates)

Harold S. Yood, MD, *Chairman* Plainfield
George T. Hare, MD,

Vice-Chairman Haddon Heights

Angelo S. Agro, MD, *Secretary* Haddonfield

Francis J. Lumia, MD, *Delegate* Allentown

Carlo Porcaro, MD,

Alternate Delegate Newark

Harold R. Reeve, MD,

Member-at-Large Mount Holly

Robert L. Wegryn, MD,

Member-at-Large Elizabeth

Robert J. Weierman, MD,

Immediate Past-Chairman South Orange

Diana C. Gore,

MSNJ Staff Liaison Lawrenceville

JEMPAC, Conference Committee with

(Established at request of JEMPAC—June 25, 1967)

Irving P. Ratner, MD Willingboro

Richard H. Sharrett, MD North Plainfield

William E. Ryan, MD Pennington

Legislation

(1) Federal Keymen (Mechanism established by MSNJ—April 4, 1954—to serve as official intermediaries between MSNJ and the federal legislators): 14 Congressional District Keymen and 2 Senatorial Keymen.

(2) State Keymen (Mechanism established by MSNJ—July 13, 1952): Keymen in 40 legislative districts/21 component societies.

Medical Assistance Advisory Council

(Established at the request of the New Jersey Department of Human Services—1980)

James Q. Atkinson, MD Vincentown

Thomas S. Bellavia, MD Hasbrouck Heights

Medical Assistants, New Jersey Society of

(Liaison requested by Society—September 15, 1963)

Giovanni Lima, MD Kearny

Joseph C. Lucci,

MSNJ Staff Liaison Lawrenceville

Medical Liaison Committees

(High-level conference groups for discussion and consideration of items of mutual interest)

Paul J. Hirsch, MD, *President* Bridgewater

Douglas M. Costabile, MD,

President-Elect Murray Hill

Joseph A. Riggs, MD,

First Vice-President Haddonfield

William E. Ryan, MD,

Second Vice-President Pennington

Palma E. Formica, MD,

Immediate Past-President Old Bridge

Bernard Robins, MD, *Secretary* Union

Gerald H. Rozan, MD, *Treasurer* Wayne

Vincent A. Maressa, *Executive Director*,

MSNJ Lawrenceville

(1) Medical-Dental

(Liaison requested by Dental Society—June 10, 1951)

(2) Medical-Hospital

(Liaison established by MSNJ—October 25, 1953)

(3) Medical-Legal

(Liaison established by MSNJ—October 25, 1953)

(4) Medical-Nursing

(Liaison established by MSNJ—April 4, 1954)

(5) Medical-Osteopathic

(Liaison requested by Osteopathic Association—September 17, 1961)

(6) Medical-Pharmaceutical

(Liaison established by MSNJ—July 26, 1953)

Mental Retardation, Governor's Council on the Prevention of

(Appointed by the Governor—June 22, 1984)

Stanley S. Bergen, Jr, MD Newark

Nursing Models Incentive Reimbursement Program Proposals Review Panel

(Representation requested by the Department of Health—July 12, 1989)

Vincent A. Maressa Lawrenceville

Osteopathic Physicians and Surgeons, New Jersey Association of

(Invitation to attend Board meetings extended to MSNJ President—July 24, 1986)

Paul J. Hirsch, MD Bridgewater

Pharmaceutical Assistance to the Aged and Disabled Advisory Council

(Appointed by Commissioner of the Department of Human Services—physician representation requested by Division of Medical Assistance and Health Services—December 19, 1980)

Frank J. Malta, MD Toms River

Pharmacopoeial Convention, The United States

(Delegate authorized to be seated—August 1988)

Joseph N. Micale, MD North Bergen

Poison Information and Education System, Advisory Board to New Jersey

(Representation requested by Department of Health—January 21, 1983)

Rudolf E. Schwaeble, MD Mendham

Radiation Protection, Advisory Committee on Nuclear Medicine to New Jersey Commission on

(Consultants in nuclear medicine appointed by Commission—November 20, 1966)

Henry J. Powsner, MD Princeton

Radiation Protection, Ad Hoc Committee on Educational Project of the Commission on

(Appointed by Board of Trustees—November 20, 1988)

Carl Restivo, Jr, MD Jersey City

Radiation Protection, Consultant Serving New Jersey Commission on

(Nomination for appointment to Commission requested March 17, 1963)

Frank Gingerelli, MD Hackensack

Resolutions, Committee on Annual Meeting

(Established by Board of Trustees July 18, 1971, to review all resolutions in advance of the Annual Meeting)

Edward A. Schauer, MD,

Chairman Farmingdale

Harry M. Carnes, MD Audubon

Palma E. Formica, MD Old Bridge

Safety Council, New Jersey State

(Provided in Council Bylaws—1962)

Paul J. Hirsch, MD Bridgewater

Society for the Assistance of New Jersey Physicians and their Families, The

(Liaison requested by Society—May 17, 1959)

Joseph R. Jehl, MD Clifton

State Board of Medical Examiners

(Member of MSNJ executive staff to attend monthly meetings—per Board of Trustees, August 8, 1979)

Martin E. Johnson Lawrenceville

Statewide Health Coordinating Council (SHCC) and/or its Review Committee

(Liaison established January 15, 1978)

A. Ronald Rouse Lawrenceville

Student Association, Medical Society of New Jersey

(Formed July 17, 1977)

Palma E. Formica, MD Old Bridge

Uninsured, Steering Committee on Health Issues of the

(MSNJ participation requested by Department of Health—March 7, 1986)

Vincent A. Maressa Lawrenceville

UMDNJ, Foundation of the

(MSNJ representative appointed yearly by the Board of Trustees to serve as a Trustee, pursuant to the Bylaws of the Foundation—1979)

Arthur Bernstein, MD South Orange

Waste Management, Advisory Council on Solid

(Appointed by Governor—April 1989)

Stanley R. Lane, MD Moorestown

NEW JERSEY MEDICINE

Published monthly under the direction of the Committee on Publication

Harry M. Carnes, MD, Chairman

Richard M. Ball, MD

LaVerne Fioretti

William V. Harrer, MD

Monroe S. Karetzky, MD

Avrum L. Katcher, MD

Clement H. Kreider, Jr, MD

John H. Lifland, MD

Alan J. Lippman, MD

Robert M. MacMillan, MD

Helio J. Malinverni, MD

Donald W. Orth, MD

Leon G. Smith, MD

Morris Soled, MD

Louis S. Zeiger, MD

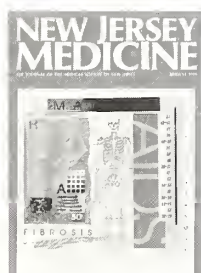
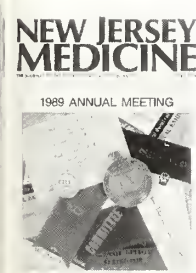
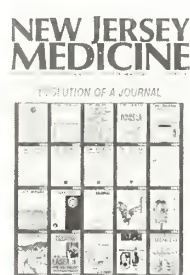
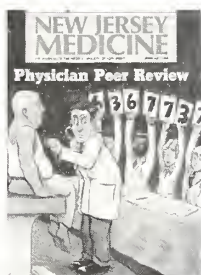
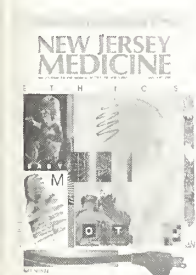
Howard D. Slobodien, MD, Editor-in-Chief

Geraldine R. Hutner, MA, Executive Editor

Robin L. Kennett, Editorial Assistant

INDEX TO PAGES

Pages	No.	Date	Pages	No.	Date
1-76	1	January 1989	497-580	7	July 1989
77-156	2	February 1989	581-656	8	August 1989
157-240	3	March 1989	657-740	9	September 1989
241-326	4	April 1989	741-826	10	October 1989
327-420	5	May 1989	827-922	11	November 1989
421-496	6	June 1989	923-1002	12	December 1989



Academy of Medicine of New Jersey

president's report, 61, 219, 804

Acromegaly

as the amenorrhea-galactorrhea syndrome [Goldman], 887

AIDS

AIDSline, 61

blood donor must answer questions, 592

human bite is a deadly weapon, 338

impaired bone marrow [Mehta], 623

physician's duty to disclose that his patient has AIDS

[Nissenbaum], 123

pregnant women and AIDS, 60

testicular seminoma [Szypula], 295

tests, 337

transmission of AIDS, 137

vaccine suits, 338

Ammonia

encephalopathy [Peltz], 554

Aortic Diseases

aortic ballon valvuloplasty [Cha], 611

diagnostic dilemma [Mayer], 109

Asthma

due to parasitic infestation [Strazzella], 947

steroid use in asthmatics [Adelman], 457

Bile Duct Diseases

resection of proximal bile duct cancer [Gardiner], 797

Biomedical Ethics

Assembly for Health Decisions [Fennelly], 440

challenge of ethics [Hill], 43

committee on biomedical ethics [Pickens], 38

communication and altered perceptions [Burk], 50

courts and the PVS patient [Armstrong], 27

covenant-making and medical ethics [Todd], 33

democratic imperative [Murphy], 55

ethics in high school [Caruso], 53

ethics or enigmas [Slobodien], 21

gastrostomy tube-feeding [Nevins], 779

medical education's ethical challenge [Bergen], 39

medical ethics by osmosis [Young], 442

MSNJ and biomedical ethics [Formica], 24

nursing homes and ethics committees [Somers], 45

quest for balance [Cassidy], 35

time of change [Fennelly], 23

Book Reviews

Abrams J: Synopsis of Cardiac Physical Diagnosis, 437

Alberts B, Bray D, Lewis J: Molecular Biology of the Cell, 680

Anthanosoulis C, Green R, Pfister R, Robertson G: Interventional Radiology, 528

Barnes PJ, Rodger IW, Thomson NC: Asthma, 766

Bar-Or O: Advances in Pediatric Sport Sciences, 944

Beahrs OH, Hensen DE, Hutter RVP, Myers MH: Manual for Staging of Cancer, 232

Bellet PS: Symptoms and Signs, in Infants, Children, and Adolescents, 437

Bernstein JM, Ogra PL: Immunology of the Ear, 679

Cavanagh HD: The Cornea: World Congress, 343

Colvin RB, Bhan AK, McCluskey RT: Diagnostic Immunopathology, 851

Creger WP: Annual Review of Medicine, 851

Cummings, CW: Otolaryngology. Head and Neck Surgery, 851

Daniele RP: Immunology and Immunologic Diseases of the Lung, 69

deGraaf CN, Viergever MA: Information Processing in Medical Imaging, 943

Ernest JT: Year Book of Ophthalmology, 943

Facts on File: Surgery on File, 266

Freeman DZ: Psychiatry and Applied Mental Health, 344

Green Publishing Associates: Current Protocols in Molecular Biology, 527

Griffith HW: Medical Tests and Diagnostic Procedures, 852

Helms CA: Fundamentals of Skeletal Radiology, 603

Hood AF, Kwan TH, Burnes DC, Mihm MC: Primer of Dermatopathology, 680

Huber PW: Liability: The Legal Revolution, 266

Illis LS: Spinal Cord Dysfunction, 603

Kowalski RE: Cholesterol and Children, 603

LaFond RE: Cancer: The Outlaw Cell. Second Edition, 69

Lee JKT, Sagel SS, Stanley RJ: CT with MRI Correlation, 343

Lee JKT, Sagel SS, Stanley RJ: CT with MRI Correlation, 2nd Edition, 527

Mandal AK, Jennette JC: Diagnosis and Management of Renal Disease and Hypertension, 69

Mishell DR, Kirschbaum TH, Morrow CP: 1988 Yearbook of Obstetrics and Gynecology, 150

Mollison PL, Engelfriet CP, Contreas M: Blood Transfusion in Clinical Medicine, 265

Park MK: Pediatric Cardiology for Practitioners, 943

Partain CL, Price R, Patton JA: Magnetic Resonance Imaging, 2nd Edition, 943

Saleh JW: Laparoscopy, 232

Samter M: Immunological Diseases, 265

Smith LH, Wyngaarden JB: Cecil Review of General Internal Medicine, 766

Snider HC: Jury of My Peers, 851

Solomon MA: Magnetic Resonance Video Review, MRI of the Knee, 943

Wagner DK: 1988 Yearbook of Emergency Medicine, 150

Wanebo HJ: Hepatic and Biliary Cancer, 344

Weeder RS: Surgeon. View from Behind the Mask, 604

Weil WB, Benjamin M: Ethical Issues at the Onset of Life, 679

Wilson J, Hunt T: Molecular Biology of the Cell. The Problems Book, 680

Wolf BS, Neiman RS: Disorders of the Spleen, 528

Cardiomyopathy

alcoholic cardiomyopathy [Kosinski], 773

Chlamydia Trachomatis

chlamydia trachomatis [Lombardo], 289

Chondrosarcoma

malignant lymphoma [Murakata], 629

Confusional State

chronic confusional state [Mullally], 541

Deaf Persons

with a hearing therapist [Klein], 68

Defensive Medicine

automobile injuries, 336

automobile liability reform law, 83

complaints, 336

contingency fee payment, 432

election outcome for liability, 257

emotional harm from fetal death, 257

feelings and manners [Shapiro], 207

financial disclosure law, 162, 163, 251

hedonic damages awarded to patients, 833

importance of documentation in

peer review [Kingsley], 185

isotretinoin guidelines, 518

legislation, 310, 637
liability of an HMO, 670
litigation assistance, 591
malpractice pitfalls, 664
malpractice surcharge, 162
new drugs, 337
PACS, 935
prevention of handgun deaths [Eilers], 875
pro bono work, 663
professional liability, 11, 89, 169, 257, 337, 431, 517, 591, 670, 757, 833, 933
professional liability claims without merit, 218
relief: respite or reality? 759
surcharge hearing, 59
surcharge proposal, 249, 662
surgeon's technique, 517
to disclose a patient has AIDS [Nissenbaum], 123
tort reforms, 169, 431
uncompensated care trust fund [Coye], 189
wrongful-birth action, 12
your prescription—an instrument of your license [Malta], 203

Dilatation and Curettage

D & C results improved by hysteroscopy [Goldfarb], 277

Drug Therapy

methotrexate in the rheumatic diseases [Solomon], 213
steroid use in asthmatics [Adelman], 457
success of ceftizoxime in *E. coli* ventriculitis [Coant], 211

Dysgerminoma

early stage pure seminoma testis [Zablow], 800

Endoscopy

endoscopic nasal surgery [Chun], 883

Environmental Concerns

medical waste, December insert
microbiological contamination of the ocean and human health [Coye], 533

Glottis

radiotherapy T₁ glottic carcinoma [Zablow], 897

Health Insurance of the Aged and Disabled, Title 18 carriers, 251

expenditure targets, 752

Medicare, 662, 721

Medicare/ICD-9 codes, 339

Medicare waiver [Coye], 189

state programs for the elderly [Villane], 795

reform, 753

transition, 339, 503

Hemorrhage

bilateral adrenal hemorrhage [Champlin], 633

History

Muriel M. Gardiner [Rogers], 193

seal of approval [Hutner], 959

Hospitals

NJ Hospital Association report, 59, 479

teaching psychiatry in community hospitals [Granet], 99

Hypogonadism

polyendocrine failure with hypogonadism [Alfonso], 531

Lungs

idiopathic unilateral hyperlucent lung [Patel], 557

Maternal and Child Care

SIDS counseling program, 7

Medical Education

academic health center in CME [Moutrie], 707

AMNJ: a commitment to education [Alessi], 693

cme and MSNJ [Toro-Echague], 688

computer connection [Marcus], 713

continuing education [Slobodien], 677

continuing education calendar, 65, 145, 223, 303, 405, 485, 567, 641, 727, 807, 909, 989

continuing medical education [Thorpe], 686

down-to-earth medical education [Goodstein], 709

financing medical education [Lieberman], 551

hospital medical education [Wang], 701

NJHA and continuing education [Scibetta], 703

pharmaceutical industry and CME [Heller], 715

role of AMNJ [Heitzmann], 699

time of change for CME [Dixon], 717

what's so special about CME? [Lippman], 682

Medical Society of New Jersey

annual meeting, 173, 525, 572, 897

auxiliary report [Geib], 138, 218, 310, 565, 724, 903, 986

capitol commentary [Martin], 8, 87, 163, 255, 336, 427, 515, 587

committees and councils, 903

directory, 335

editor's desk, 21, 95, 177, 249, 340, 435, 525, 599, 677, 765, 847, 939

evolution of a journal [Hutner], 269

golden merit award recipients, 445

inaugural address [Hirsch], 451

in memoriam, 70, 151, 233, 315, 413, 486, 569, 647, 733, 815, 916, 995

JEMPAC, 408

journal, 249

letters and viewpoints, 26, 231, 440, 547, 605, 855

liaison representatives, 972

medical ethics, 504

membership newsletter, 7, 83, 162, 249, 335, 503, 662, 751, 839, 929

new members, 312, 482, 725, 904

nominating committee report, 301

physician service to Afghan refugees, 970

president's page, 24, 93, 173, 261, 339, 455, 521, 595, 673, 761, 845, 935

public relations, 84

quality of care and quality of caring [Slobodien], 177

seal [Hutner], 959

senior medical courtesy, 95

statement of ownership, 906

trustees' report, 59, 135, 218, 407, 479, 561, 635, 721, 899, 984

Myxoma

left atrial [Tabbalat], 785

Narcolepsy

current concepts [Nahmias], 617

Neoplasms

carcinoid tumor of the testicle [Rosenberg], 299

chondrosarcoma and malignant lymphoma [Murakata], 629

cytological diagnosis of breast cancer [Rangwala], 859

early stage pure seminoma testis [Zablow], 800

limited resections for lung cancer [Wetstein], 197

lung cancer [Scheinok], 951

lung cancer limited resections (letters), 606

pediatric hematology/oncology, 856

radiotherapy T₁ glottic carcinoma [Zablow], 879

resection of proximal bile duct cancer [Gardiner], 797

Nursing Homes

and ethics committees [Somers], 45

Obstetrics

epidemiology of congenital syphilis [Petrone], 965

obstetricians' dilemma [Hansen], 848

trends in cesarean section rates [Halpin], 897

Pancreas

pancreatitis of divisum [Kalkay], 281

Peer Review Organizations

importance of documentation [Kingsley], 185
 importance of peer review (letter), 605
 in New Jersey [Dwyer], 127
 intervening care [Kingsley], 286
 PRO of New Jersey (letter), 605
 quality assessment mechanism in Medicare contract with
 The PRO of New Jersey, Inc. [Kingsley], 105
 quality reviews, 84

Percutaneous Transluminal Coronary Angioplasty

in anomalous coronary artery [Goulah], 548

Pneumonia

varicella pneumonia in the adult [Conti], 475

Poisoning

ciguatera fish [Hashmi], 469

Politics

capitol commentary [Martin], 8, 87, 163, 255, 336, 427, 515
 financial disclosure law, 162, 163
 legislative update [O'Hare], 507
 prevention of handgun deaths [Eilers], 875
 race for governor, 769

OBITUARIES

Alpert, Elmer, 569	Fost, William H, 70	Mockett, Walter William, 71
Balsamo, Joseph John, 995	Franklin, Charles Montanye, 70	Monaco, Saverio Anthony, 815
Baum, Lewis F, 916	Friedland, Walter, 70	Muccia, John J, 570
Barberio, Angelo Albert, 315	Friedman, Myron John, 486	Murray, Edwin Nelson, 316
Barnes, William Charles, Jr, 70	Gadek, Stanley Anthony, 233	Murray, William Francis, 233
Barris, Leonard Ralph, 413	Galitzin, Alvin L, 734	Naden, Randall Stedman, 233
Behringer, William Hayman, 733	George, NJ, 648	Newmeyer, Joseph, 916
Bennett, Gardiner Cabell, 647	Giannini, Salvatore Joseph, 233	Nova, Harvey Ronald, 570
Bennett, Robert Eugene, 413	Greenberg, Philip, 70	Nucci, Cyrus Giulio, 996
Bensel, Arlington, 995	Gross, Robert John, 151	O'Kane, Michael Joseph, 734
Berry, Clarence Hartley, 151	Hamilton, Richard Bothwell, 648	Parent, Sol, 648
Bonvicino, Richard John, 647	Hartman, Winfield Leinbach, 315	Patterson, John C, 996
Brady, Matthew Andrew, 647	Hermann, John H, Jr, 734	Pfeiffer, Carl Curt, 316
Brandman, Otto, 733	Hillsman, Robert Bryan, 916	Pinderhughes, John Lloyd, 233
Brooks, Sidney, 413	Hipolito, Jose Anselmo, 486	Poller, Frederick Kristian, 570
Buffington, Richard, 647	Horowitz, Leo, 648	Prince, Robert Anthelme, 916
Burrill, Benjamin Brooks, Jr, 413	Iraggi, James Vincent, 648	Rampona, Joseph Mercer, 649
Caceres, Rudolfo B, 733	Islami, Abdol Hossein, 70	Rathmell, Thomas Kessinger, 71
Campo, Anthony Guy, 413	Jacobs, William Robert, 815	Reilly, John Vincent, 649
Cane, Carlos Mario, 413	Jones, David Walton, 486	Rosenbaum, Samuel, 71
Carlander, Oswald Rudolph, 70	Joseph, Solomon, 414	Rubens, Otto, 233
Cartnick, Louis Charles, 647	Joshi, Sadanand Balwant, 315	Ruby, Victor M, 316
Caccio, William L, 733	Judd, Alvan Bradford, 995	Russomanno, Raymond Lawrence, 734
Caton, John Edward, 414	Kain, Thomas Michael, Jr, 648	Sasso, Albert, 233
Chalfin, Lenn Jay, 995	Kanning, Frederick Richard, 815	Schwab, George Peter, 734
Chiofalo, Anthony, 733	Keith, Theodore, 815	Schaefer, John, 151
Clark, John James, 486	King, Alden Park, 916	Schwager, Alfred Joseph, 649
Cloud, Albert William, 569	Kley, Edward Charles, 71	Scialli, Vincent Antonio, 649
Coughlin, John P, 995	Konzelmann, Henry Joseph, 815	Scolamiero, Pasquale Joseph, 71
Cunneff, Raymond Leo, Jr, 733	Lance, Edward Merriman, 315	Shafer, Albert Henry, 71
daSilva, Jose Palma, 733	Lane, Milton, 996	Sheeran, Archibald Daniel, 649
Dixon, John F, Jr, 414	Langgaard, Charles Erich, 151	Shepardson, Robert Marshall, 916
Driscoll, Raymond Sylvester, 995	Leir, Jacob Krevin, 315	Shore, Seymour Harry, 996
Duffy, Joseph Francis, 70	Levin, Joseph, 815	Sipin, Mario Sison, 734
Dupuy, Jean Gabriel, 486	Levy, Abram, 71	Smith, Benjamin Earl, 486
Dyer, Edward Harvey, 647	Lim, Anna, 71	Speranza, Joseph John, 316
Effron, Abraham Samuel, 000	Lowenthal, Martin, 815	Stillwell, John Clifford, 649
Eisenstadt, Lester Warner, 414	Lynch, Philip Vincent, 569	ter-Kuile, Reinold William, 71
Ellenson, Solomon Sidney, 647	Lynn, Irving, 71	Terlecky, Irene Stephania, 316
Elmer, Alfred Cornwell, 734	Magalindan, Zenaida Abadam, 315	Tucker, Sidney, 649
Emory, George Bache, Jr, 151	Magnes, Max, 151	VanMeter, Ralph Harmon, 916
Errgong, William Henry, 569	Markel, Albert Gross, 996	Verdon, Robert Edward, 414
Fahrenbruch, Frederick Daniel, 414	Marshall, Irving, 648	Weigl, Alfred William, 570
Felden, Botho Friedrich-Wilhelm, 70	Mayer, David McCullagh, 569	Willner, Milton Michael, 996
Ferriss, Ruth Bridgman, 233	McCarthy, George Logan, 570	Wilson, John Milton, 570
Finkelstein, Max, 151	McIlveen, Marion, 570	Wishbow, Alexander J, 414
Flanagan, James Francis, 569	Melosh, William Donald, 734	Young, Alfred Dennis, 649
Foord, Edward, 486	Misko, Albert Francis, 734	Zimmerman, Coler, 996

Pages	No.	Date	Pages	No.	Date
1-76	1	January 1989	497-580	7	July 1989
77-156	2	February 1989	581-656	8	August 1989
157-240	3	March 1989	657-740	9	September 1989
241-326	4	April 1989	741-826	10	October 1989
327-420	5	May 1989	827-922	11	November 1989
421-496	6	June 1989	923-1002	12	December 1989

Practice Opportunities

placement file, 62, 139, 220, 313, 411, 483, 565, 639, 724, 805, 905, 988

Psychiatry

gift of life [Jacobson], 615
Muriel M. Gardiner [Rogers], 193
prevention of handgun deaths [Eilers], 875
teaching residents in a community hospital [Granet], 99
treating anxiety in primary care [Weiss], 791

Pulmonary

limited resections for lung cancer [Wetstein], 197

Pyoderma

pyoderma gangrenosum [Seitzinger], 465

Residents

teaching in a community hospital [Granet], 99

Skin Cancer

chronic arsenicism [Bickley], 377
cutaneous T-cell lymphoma [Worobec-Victor], 395
dysplastic nevi and melanoma [Migraum], 389
Melanoma-Pigmented Tumor Clinic [Devereux], 401
Mohs micrographic surgery [Morman], 369
New Jersey skin cancer screening program [Papa], 353
skin sense [Papa], 345
sun protection [Berger], 348
tretinoin therapy for precancerous skin [Papa], 361
xeroderma pigmentosum [Lambert], 383

Sleep Apnea

flow-volume curves [Nahmias], 115

Steroids

use in asthmatics [Adelman], 457

Suicide

teen suicide [Geib], 139

Synovitis

aseptic synovitis [Barone], 473

Syphilis

epidemiology of congenital syphilis [Petrone], 965

Testicular Diseases

carcinoid tumor of the testicle [Rosenberg], 299
seminoma [Szypula], 295

Thyroid

Euthyroid hypertri-iodothyronemia [Goldman], 962

Tobacco Dependence

for-profit smoking-cessation programs and their clients [Caplan], 181
smoking aboard aircraft, 752

University of Medicine and Dentistry

monthly report, 60, 137, 309, 410, 481, 564, 636, 723, 804, 902, 986

Ventriculitis

success of ceftizoxime [Coant], 211

Vocal Cords

Radiotherapy T₁ glottic carcinoma [Zablow], 879

AUTHOR INDEX

Abrams J

Laparoscopy (Book Review), 232
1988 Year Book of Obstetrics and Gynecology (Book Review), 150

Adelman M, Safirstein BH: Steroid use in asthmatics, 457

Alessi AA, Davidson R, Heitzmann CJ: AMNJ: A commitment to education, 693

Alfonso JR, Goldman MH, Kocher J: Polyendocrine failure with hypogonadism, 531

Arlen H

Immunology of the Ear (Book Review), 679
Otolaryngology. Head and Neck Surgery (Book Review), 851

Armstrong PW, Colen BD: The courts and the PVS patient, 27

Bansil RK: Deaf persons and a hearing therapist (letter), 68

Baranski C, see Lieberman

Barone JE, see Barone JG

Barone JG, Wang CJ, Barone JE: Aseptic synovitis, 473

Bergen SS

Medical education's ethical challenge, 39
UMDNJ monthly report, 60, 137, 309, 410, 481, 564, 636, 723, 804, 902, 986

Berger RS: Sun protection and skin cancer, 348

Bickley L, Papa CA: Chronic arsenicism, 377

Bielory L

Blood Transfusion in Clinical Medicine (Book Review), 265
Immunological Diseases (Book Review), 265
Immunology and Immunologic Diseases of the Lung (Book Review), 69
Laboratory Investigations of Immunological Disorders (Book Review), 150

Bourns EG: Physicians and politics (letter), 855

Brenner A, see Wetstein

Budin JA, see Champlin

Burk K: Communication and altered perceptions, 50

Campo A: MSNJ auxiliary, 138, 218

Caplan RL, Greenberg M, Bellet L: For-profit smoking-cessation programs and their clients, 181

Caruso DM, Smith HM: Ethics in high school, 53

Cassidy RC: A quest for balance, 35

Cha SD, Kothari AG, Weiner RI, Kashnikow C, Wappel MA, Roman C, Maranhao V: Aortic balloon valvuloplasty, 611

Champlin AM, Budin JA: Bilateral adrenal hemorrhage, 633

Chun TH, Morrow TA: Endoscopic nasal surgery, 883

Cinotti A: Year Book of Ophthalmology (Book Review), 944

Coant PN, Sussman SJ, Fong-deLeon E: Success of ceftizoxime in *E. coli* ventriculitis, 211

Cohen B, see Peltz

Cohen F: AMNJ report, 804

Colen BD, see Armstrong

Constad WH: The Cornea: World Congress (Book Review), 343

Conti JA, Karetzky MS: Varicella pneumonia in the adult, 475

Coye MJ, Goldoft M: Microbiological contamination of the ocean and human health, 533

Davidson R, see Wang; Alessi

Derman A, see Kalkay

Devereux DF: Melanoma-pigmented tumor clinic, 401

Dixon RE: A time of change for CME, 717

Dwyer WA: Physician peer review in New Jersey, 127

Eilers: Prevention of handgun deaths, 875

Engler PE, see Scheinok

Erba P, see Zablow

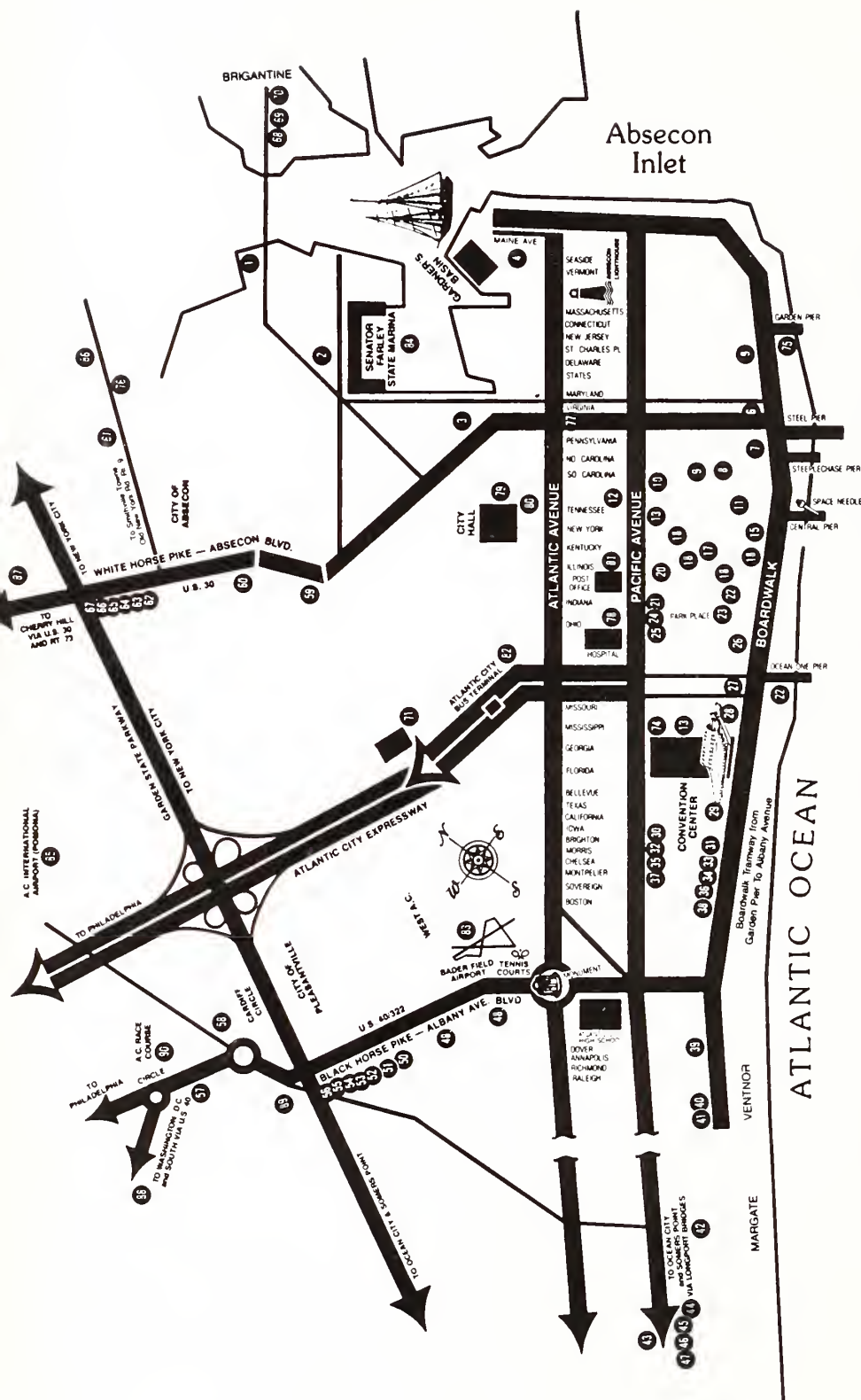
Fadil R: The physician and patient, 547

Fennelly JF

A time of change, 23
Assembly for Health Decisions (letter), 440
Ethical Issues at the Onset of Life (Book Review), 679

- Fong-deLeon E**, see **Coant**
- Formica PE**
 Hotline, 339
 Mantle of leadership, 173
 MSNJ and biomedical ethics, 24
 Physician involvement, 93
 Presidential address, 455
 Professionalism revisited, 261
- Frank E**, see **Meyer**
- Frenkel LD**: Viral diagnostic laboratory (letter), 441
- Freund CF**, see **Petrone**
- Gardner B**: Resection of proximal bile duct cancer, 797
- Gascon P**, see **Mehta**
- Geib M**: Auxiliary report, 138, 218, 310, 565, 724, 903, 986
- George JE**
 Jury of My Peers (Book Review), 851
 Liability. The Legal Revolution (Book Review), 266
 Professional liability, 11, 89, 169, 257, 337, 431, 517, 591, 670, 757, 833, 933
- Geschwind N**, see **Mullally**
- Goldfarb HA**: D&C results improved by hysteroscopy, 277
- Goldman MH**
 Acromegaly as the amenorrhea-galactorrhea syndrome, 887
 Euthyroid hypertri-iodothyronemia, 962
 Polyendocrine failure with hypogonadism, 531
- Goldoft M**, see **Coye**
- Goodstein RK**: Down-to-earth medical education, 709
- Goulah RD, Goldstein JE, Haft JI**: PTCA in anomalous coronary artery, 548
- Granet RB**: Teaching psychiatry to primary care residents in a community hospital, 99
- Grossman MD**, SBME update, 903
- Haft JI**, see **Tabbalat**
- Halpin GJ, Rose E, Shapiro E**: Trends in cesarean section rates, 867
- Hansen GF**: Obstetricians' dilemma, 848
- Harrer WV**: Diagnostic Immunopathology (Book Review), 851
- Harris C**: Peer review (letter), 605
- Hashmi MA, Sorokin JJ, Levine SM**: Ciguatera fish poisoning, 469
- Haycock C**: Advances in Pediatric Sport Sciences (Book Review), 944
- Heitzmann CJ**: Role of AMNJ, 699
- Heller R**: The pharmaceutical industry and CME, 715
- Henson DE**, see **Scheinok**
- Hill TP, Strong MS**: The challenge of ethics, 43
- Hirsch PJ**
 Inaugural address, 451,
 President's page, 521, 595, 673, 761, 845, 935
- Horner NB**
 Computed Tomography with MRI Correlation (Book Review), 527
 Information Processing in Medical Imaging (Book Review), 943
 Interventional Radiology (Book Review), 528
 Magnetic Resonance Imaging, 2nd Edition (Book Review), 943
 Magnetic Resonance Video Review, MRI of the Knee (Book Review), 943
- Huff K**, see **Mullally**
- Hutner G**
 Evolution of a journal, 269
 Seal of approval, 959
- Hutter RVP**, see **Scheinok**
- Jacobson RH**: The gift of life, 615
- Johnson ME**, see **Toro-Echague**
- Kalkay MN, Derman A**: Pancreatitis of pancreas divisum, 281
- Karel JR**: 1988 Year Book of Emergency Medicine (Book Review), 150
- Karetzky M**
 Asthma (Book Review), 766
 Current concepts in narcolepsy, 617
 Idiopathic unilateral hyperlucent lung, 557
 Upright and supine flow-volume curves in patients with OSA, 115
 Varicella pneumonia in the adult, 475
- Kashnikov C**, see **Cha**
- Katcher AL**
 Cholesterol and Children (Book Review), 603
 Symptoms and Signs in Infants, Children, and Adolescents (Book Review), 437
- Kazem I**
 Cancer: The Outlaw Cell. Second Edition (Book Review), 69
 CT with MRI Correlation (Book Review), 343
- Kingsley DI**
 Importance of documentation in peer review, 185
 Quality assessment mechanism in Medicare contract with The PRO of New Jersey, Inc., 105
 PRO of New Jersey (Letter), 605
 PRO review of intervening care, 286
- Klein MA**: Deaf persons and a hearing therapist (letter), 68
- Klinges K**, see **Goldman**
- Kocher J**, see **Alfonso**
- Kosinski RM**: Alcoholic cardiomyopathy, 773
- Kothari AG**, see **Cha**
- Kreider CH**: Spinal Cord Dysfunction (Book Review), 603
- Kuza M**, see **Szypula**
- Lambert WC, Papa CA**: Xeroderma pigmentosum, 383
- Lee SH**: Fundamentals of Skeletal Radiology (Book Review), 603
- Levine SM**, See **Hashmi**
- Lieberman JA, Baranski C**: Financing medical education, 561
- Lippman A**
 Hepatic and Biliary Cancer (Book Review), 344
 Lung cancer limited resections (letter), 606
 Manual for Staging of Cancer (Book Review), 232
 What's so special about CME? 682
- Lombardo JM, Smith CA, Siddiqui LL, Robboy SJ**: Chlamydia trachomatis, 289
- Malta FJ**: Your prescription—an instrument of your license, 203
- Maranhao V**, see **Cha**
- Marcus S**: The computer connection, 713
- Marin GA**: Annual Review of Medicine (Book Review), 851
- Martin, C**: Capitol commentary, 8, 87, 163, 255, 336, 427, 515, 587
- Mayer, RC, Frank E**: Diagnostic dilemma of aortic aneurysms: internist's perspective, 109
- Mehta KU, Gascon P, Tannir N, Lombardo J, Robboy SJ**: Impaired bone marrow in AIDS, 623
- Middleton JR**, see **Szypula**
- Milgraum SS, Papa CA**: Dysplastic nevi and melanoma, 389
- Morman MR**: Mohs micrographic surgery, 369
- Morrow TA**, see **Chun**
- Moutrie RR, Vaun WS**: The academic health center in CME, 707
- Mullally WJ, Ronthal M, Huff K, Geschwind N**: Chronic confusional state, 541

- Murakata L, Rangwala AF:** Chondrosarcoma and malignant lymphoma, 629
- Murphy P:** The democratic imperative, 55
- Nahmias J, Karetzky M**
Current concepts in narcolepsy, 617
Upright and supine flow-volume curves in patients with OSA, 115
- Nevins MA:** Gastrostomy tube-feeding, 779
- Nissenbaum GD:** A physician's duty to disclose that his patient has AIDS, 123
- O'Hare J:** Legislative update, 507
- Padberg FT:** Surgeon. View from Behind the Mask (Book Review), 604
- Papa CA**
Chronic arsenicism, 377
Dysplastic nevi and melanoma, 389
New Jersey skin cancer screening program, 353
Primer of Dermatopathology (Book Review), 680
Skin sense, 345
Tretinoin therapy for precancerous skin, 361
- Parkin WE, see Petrone**
- Patel H, Karetzky MS:** Idiopathic unilateral hyperlucent lung, 557
- Peltz S, Schwartzmann S, Cohen B:** Ammonia encephalopathy, 554
- Perez-Blanco M, see Rangwala**
- Petrone ME, Teter MK, Freund CG, Porter J, Parkin W, Spitalny KC:** Epidemiology of congenital syphilis, 965
- Pickens RL:** Committee on biomedical ethics, 38
- Poppick HM:** Medical Tests and Diagnostic Procedures (Book Review), 852
- Porter J, see Petrone**
- Rangwala AF**
Cytological diagnosis of breast cancer, 859
see Murakata
- Reilly J, see Rangwala**
- Ribot S:** Diagnosis and Management of Renal Disease and Hypertension, (Book Review), 69
- Robertson PD, see Scheinok**
- Robboy SJ; see Lombardo; Mehta**
- Rogers FB:** Dr. Muriel M. Gardiner: psychiatrist and philanthropist, 193
- Roman C, see Cha**
- Ronthal M, see Mullally**
- Rose E, see Halpin**
- Rosenberg JW, Yang M:** Carcinoid tumor of the testicle, 299
- Rossen SI:** A call for letters (letter), 231
- Rothfeld EL**
Pediatric Cardiology for Practitioners (Book Review), 943
Synopsis of Cardiac Physical Diagnosis (Book Review), 437
- Rouse AR, see George**
- Rush B**
AMNJ report, 61
Surgery on File (Book Review), 266
- Safirstein BH; see Adelman; Strazzella**
- Sanfilippo LJ, see Zablow**
- Scheinok PA, Engler PE, Robertson PD, Hutter RVP, Henson DE:** Lung cancer. Difference in age at diagnosis between men and women, 951
- Schneider D, Greenberg MR, Donaldson MH:** Pediatric hematology/oncology (letter), 856
- Schwartzman S, see Peltz**
- Scibetta LP:** NJHA and continuing education, 703
- Seitzinger JW:** Pyoderma gangrenosum, 465
- Sen P, see Szypula**
- Shapiro E, see Halpin**
- Shapiro ET:** Of feelings and manners, 207
- Shuster M:** Disorders of the Spleen (Book Review), 528
- Siddiqui LL, see Lombardo**
- Slobodien H**
Cleopatra's needle, 340
Conflict of interest or chainsaw massacre, 435
Continuing medical education, 677
Dilemma, 755
Ethics or enigmas? 21
Even if it hurts, 599
February, 95
MSNJ annual meeting, 525
Our journal, 249
Peer review, part 1, 847
Quality of care and quality of caring, 177
Visions of sugar plums, 939
- Smith CA, see Lombardo**
- Smith HM, see Caruso**
- Soled M**
Cecil Review of General Internal Medicine (Book Review), 766
Physician compassion (letter), 855
- Solomon SD:** Methotrexate in the rheumatic diseases, 213
- Somers AR:** Nursing homes and ethics committees, 45
- Sorokin JJ, see Hashmi**
- Spitalny KC, see Petrone**
- Strazzella WD, Safirstein BH:** Asthma due to parasitic infestation, 947
- Strong MS, see Hill**
- Sugerman AA:** Psychiatry and Applied Mental Health (Book Review), 344
- Sussman SJ, see Coant**
- Sypek DS, see Goldman**
- Szypula G, Sen P, Tan KL, Middleton JR, Kuza M:** Unusual presentation: Testicular seminoma, 295
- Tabbalat RA, Haft JI:** Left atrial myxoma, 785
- Tan KL, see Szypula**
- Tannier N, see Mehta**
- Teter MJ, see Petrone**
- Thorpe JH**
Continuing medical education, 686
What's so special about CME? 682
- Tice C, see Bergen**
- Todd JS:** Covenant-making and medical ethics, 33
- Toro-Echague B, Johnson ME:** CME and MSNJ, 688
- Vaun WS, see Moutrie**
- Villane AM:** State programs for the elderly, 795
- Wang CJ, see Barone JG**
- Wang, SF, Davidson R:** Hospital medical education, 701
- Wappel MA, see Cha**
- Weiner RI, see Cha**
- Weiss KJ:** Treating anxiety in primary care, 791
- Wetstein L:** Lung resection (Letter), 607
- Wetstein L, Brenner A:** Limited resections for lung cancer, 197
- Worobec-Victor SM:** Cutaneous T-cell lymphoma, 395
- Yavelow J**
Current Protocols in Molecular Biology (Book Review), 527
Molecular Biology of the Cell (Book Review), 680
Molecular Biology of the Cell. The Problems Book (Book Review), 680
- Young K:** Medical ethics by osmosis (letter), 442
- Zablow A, Erba P, Sanfilippo LJ**
Early stage pure seminoma testis, 800
Radiotherapy T₁ glottic carcinoma, 879



GREATER ATLANTIC CITY HOTELS/MOTELS/POINTS OF INTEREST

- | | | | | |
|--------------------------------|--------------------------------------|-------------------------------------|------------------------------|---------------------------|
| 1. Harrah's Marina | 39. Enclave Suite Resort** | 56. Days Inn - Pleasantville | 74. Atlantic City Convention | 84. Sen. Frank S. Farley |
| 2. Trump Castle | 40. Oceanaire (Ventnor) | 57. Inn of the Dova (Cardiff) | State Marina | State Marina |
| 3. Admiral's Quarters** | 41. Mayfair By-The-Sea (Ventnor) | 58. Red Carpet Inn (Cardiff) | Atlantic City | Atlantic City |
| 4. Radisson Flaggship Resort** | 42. White Sands (Margate) | 59. Howard Johnson Hotel | International Airport | International Airport |
| 5. Showboat | 43. Residencia Inn (Somers Point) | 60. Comfort Inn North | Historic Smithville | Historic Smithville |
| 6. Trump Taj Mahal* | 44. Impala Motel (Ocean City) | 61. Marriott's Seaview Golf Resort | & Village Greene | & Village Greene |
| 7. Resorts International | 45. Santa Barbara (Ocean City) | 62. Travel Lodges | Renault Winery | Renault Winery |
| 8. Barbizon-Catalina | 46. Port-O-Call (Ocean City) | 63. Econo Lodge | Historic Wheaton Village | Historic Wheaton Village |
| 9. Carolina Crast | 47. Crossings Motor Inn | 64. Budget Host Inn | Shore Mall/Boscov's | Shore Mall/Boscov's |
| 10. Quality Inn | 48. Airport Motor Inn | 65. Hampton Inn Hotel | Atlantic City Race Course | Atlantic City Race Course |
| 11. Trinidad | 49. Best Western Inn at Golf | 66. Days Inn Absecon | & Hamilton Mall/Macy's | & Hamilton Mall/Macy's |
| 12. Flasia | 50. Tannis World | 67. Travel Inn | | |
| 13. Envoy | 51. Hampton Inn - Atlantic City | 68. Islander (Brigantine) | | |
| 14. Econo Lodge Boardwalk | 52. Comfort Inn - West Atlantic City | 69. La Sammaria (Brigantine) | | |
| 15. Atlantic Palace** | 53. Diplomat | 70. The Sea Gull (Brigantine) | | |
| 16. La Renaissance** | 54. International | 71. Atlantic City Rail Terminal and | | |
| 17. Casino Beach | 55. Ocean Club** | Site Of New Convention Center | | |
| 18. Madison House | 56. El Greco | 72. Shops On Ocean One | | |
84. Sen. Frank S. Farley
85. Atlantic City
86. Historic Smithville
87. Renault Winery
88. Historic Wheaton Village
89. Shore Mall/Boscov's
90. Atlantic City Race Course
91. Post Office
92. Bus Station
93. Bader Field Airport
94. Under construction/Casino Hotel Pending, N.J. License
**Condo



HOUSING APPLICATION
224th ANNUAL MEETING
MEDICAL SOCIETY OF NEW JERSEY
MAY 6-9, 1990

Select the hotel of your choice. Mail the entire form with one night's deposit to that hotel.

THE SANDS HOTEL, CASINO & COUNTRY CLUB (Headquarters Hotel)
INDIANA AVE. AT BRIGHTON PARK, P.O. BOX 28, ATLANTIC CITY, NJ 08404
RESERVATION DEPARTMENT 1-800-257-8580

(Please Print)

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Business Phone _____
Sharing With _____
Date of Arrival _____ Time _____
Date of Departure _____ Time _____

A one-night deposit (equivalent to room rate) is required with all reservation requests. Please send check or money order payable to the **SANDS** or complete the following:

American Express No. _____ Expiration Date _____

SCHEDULE OF RATES SUBJECT TO 12% TAX

☐ SINGLE \$75.00 ☐ One-Bedroom Suite \$225.00 ☐ Two-Bedroom Suite \$300.00

☐ DOUBLE \$75.00 (Reservations must be received prior to April 6, 1990)

Check-out time is 12 Noon. Rooms may not be available for check-in until after 3 p.m. Check-in time on Sundays is 6 p.m. FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION is required for a full refund.

PARKING: FREE PARKING TO REGISTERED GUESTS. One car per room.

☐ Check if Official Delegate County _____

CLARIDGE CASINO HOTEL

INDIANA AVE. AT THE BOARDWALK, P.O. 448, ATLANTIC CITY, NJ 08404
RESERVATION DEPARTMENT (609) 340-3434
NJ ONLY 1-800-582-7676

(Please Print)

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Business Phone _____
Sharing With _____
Date of Arrival _____ Time _____
Date of Departure _____ Time _____

A one-night deposit (equivalent to room rate) is required with all reservation requests. Please send check or money order payable to the **CLARIDGE** or complete the following:

Card # _____ Type _____ Exp. Date _____

SCHEDULE OF RATES SUBJECT TO 12% TAX

☐ SINGLE \$75.00 ☐ One-Bedroom Suite \$225.00 ☐ Two-Bedroom Suite \$300.00

☐ DOUBLE \$75.00 (Reservations must be received prior to April 5, 1990)

Check-out time is 12 Noon. Rooms may not be available for check-in until after 3 p.m. Check-in time on Sundays is 6 p.m. FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION is required for a full refund.

PARKING: FREE PARKING TO REGISTERED GUESTS. One car per room.

☐ Check if Official Delegate County _____

NOTEBOOK

TRUSTEES' REPORT

A regular meeting of the Board of Trustees was held on October 15, 1989, at the executive offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows.

Report of the President . . .

(1) Meeting with New Jersey Congressional Delegation . . .

Noted the MSNJ executive committee met with the New Jersey congressional delegation to demonstrate that MSNJ is vitally interested in health policy, legislation, and public policy affecting the health of New Jersey patients and that MSNJ is determined to participate in the legislative process.

(2) Legislative Seminar . . .

Agreed this seminar was successful in providing education and information for members of the MSNJ Board of Trustees; and in enhancing relationships with legislators.

(3) S-3429—Commissioner of Health . . .

Authorized Mr. Maressa and the officers of MSNJ to negotiate with the sponsor of the bill for a strong physician role within the Department of Health, similar to that of the federal surgeon general, and for MSNJ to have direct input into the selection of the individual to be appointed by the governor to fill the position.

(4) Professional Liability Rates . . .

Heard the New Jersey State Medical Underwriters, Inc. and MIENJ decided to file a 5 percent across-the-board professional liability insurance rate reduction, and that relativity for the category

of anesthesiology and several other specialties in class "I" will be reduced to produce an additional 9 percent reduction.

(5) **Special Meetings** . . . Noted the following dates: November 15—Conference of Presidents; James Todd, MD, AMA senior deputy vice-president, and Michael Grossman, DO, president of the State Board of Medical Examiners, will attend the November Board meeting; and January 17, 1990—Nominating Committee.

(6) **JEMPAC** . . . Noted Dr. Hirsch will serve as chairman of the JEMPAC Nominating Committee; Dr. Hirsch requested appropriate recommendations for chairman of JEMPAC, as Dr. Ryan is stepping down.

(7) **AMA Councils** . . . Unanimously endorsed Dr. Schauer as a candidate for appointment to the AMA Council on Legislation; unanimously endorsed Dr. Formica as a candidate for reappointment to the AMA Council on Long-Range Planning and Development; and invited Dr. Aiden J.M. Doyle to attend the November Board meeting to consider his request for endorsement as a candidate for appointment to the AMA Council on Ethical and Judicial Affairs.

(8) **Appointments** . . . Noted Dr. Douglas M. Costabile is chairman and member, and Dr. Joseph A. Riggs is a member of the Committee on Appointments; and Dr. Sheldon Guss is chairman and Dr. Burton M. Feinsmith is vice-chairman of the Committee on Graduates of Non-U.S. Medical Schools.

Report of Executive Director . . .

(1) **MSNJ Paid Memberships** . . . Noted that as of September 1989 total paid membership was 7,412, and the downward trend is attributed to the failure of members to complete CME requirements and the failure to pay the special assessment.

(2) **Membership Directory Supplement** . . . Noted that the *Supplement* will be available within the next 45 days.

(3) **MSNJ Financial Statements** . . . Approved the financial statements for the period ending August 31, 1989.

(4) **Litigation** . . . Filed the following information: the suit by Dr. Clemente concerning deletion of his name from the *Directory* for nonpayment of the special assessment was dismissed; a case management conference on the medical malpractice surcharge will be held with Judge Levy on November 1; the Small Medical Waste Generator Coalition (of which MSNJ is a member) is proceeding with litigation opposing the medical waste management fee schedule proposed by the Department of Environmental Protection; MSNJ is proceeding with the discovery process in federal court in the case of MSNJ versus PRO; MSNJ is proceeding to defend its position on appeal against the State Board of Physical Therapy; and the case of Dr. Sinha is not expected to be argued until January 1990.

(5) **Medicare—Assistant at Surgery** . . . Noted that this issue remains unresolved pending clarification from HCFA.

(6) **NJ State Medical Underwriters, Inc.** . . . Noted that per-

mission has been requested to grant the return of subordinated loan fund monies and to declare a dividend for the year 1978, payable to all physicians insured at the time.

(7) Task Force on Physician Assistants . . . Noted SBME has appointed a task force chaired by Fred Jacobs, MD, to review the ability of the Board to sanction the practice of physician assistants.

UMDNJ Report . . . Noted the following items from Dr. Bergen: Ruy V. Lourenco, MD, is the new dean of UMDNJ-New Jersey Medical School; and AIDS research and treatment in New Jersey is continuing.

NJ Hospital Association . . . Noted the following items: the quality measurement and management project of NJHA's research affiliate, the Health Research and Education Trust of New Jersey; five Mercer County smoke-free hospitals: Mercer Medical Center, St. Francis Medical Center, Helene Fuld Medical Center, St. Lawrence Rehabilitation Center, and Hamilton Hospital; approval to cost shift an aggregate Medicare shortfall of \$130 million for 1989 to nongovernmental payors; and New Jersey programs to identify and treat state citizens infected with AIDS.

Task Force on Shortage of Nurses & Technical Personnel . . .

(1) UMDNJ's Proposed Master of Science in Nursing Program . . . Unanimously approved Dr. Madara's request to represent MSNJ at the New Jersey Department of Higher Education, to testify on this proposed program and endorse policies in support of the program that were approved by the Board.

(2) Physician/Nurse Policy-Making Committees . . . Approved as amended the following recommendations (*italics indicate amendment*):

That MSNJ encourage hospitals to have a permanent *voting or nonvoting* nursing position on their medical staff executive committee; and

That hospitals also be encouraged to have a member of the medical staff executive committee as a permanent *voting or nonvoting* member of the equivalent policy-making nursing committee.

Committee on Physicians' Health . . . Approved the following recommendations:

That the Board of Trustees approve the outlined proposal for the Subcommittee on Alcohol and Drug Abuse (below); and

That the necessary budget to carry out the function and scope of the Subcommittee be provided and that this budget be re-evaluated at the end of the 1989-1990 administrative year.

Proposals

a. The appointment of a Subcommittee on Alcohol and Drug Abuse of the Committee on Physicians' Health;

b. That Mr. Richard Russo be invited to serve as a consultant to the Subcommittee;

c. That Subcommittee meetings be held prior to the regularly scheduled meetings of the Committee on Physicians' Health; and

d. That the function and scope of the Subcommittee will be: to sponsor one alcohol and drug abuse educational program annually; to conduct an intervention training seminar annually; and to act as the clearinghouse for MSNJ on issues concerning alcohol and drug abuse.

Unfinished Business . . .

Changed its position on bills S-722 through S-727 (insurance benefits for psychiatric care) from approved to active support; defeated the motion to collect and publish physician identifier numbers; noted MSNJ is opposed to the proposed regulations that would alter recordkeeping and dispensing and prescription requirements for

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Category: (Please check one)

☐ Member, MSNJ

☐ Subscriber, NJ Medicine

☐ Other _____

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____

schedules II, III, and IV drugs.

New Business . . . Thanked Dr. Burke for his analysis on the closing of St. Mary's Hospital in Orange; and approved that the Committee on Environmental Health review the preliminary criteria and guidelines for a low level radioactive waste disposal facility within the state and submit recommendations to the Board of Trustees. □

UMDNJ NOTES

The University of Medicine and Dentistry of New Jersey (UMDNJ) recorded an 18.13 percent increase in revenue from grants and contracts last year. UMDNJ received a total of \$61.7 million in these funds from federal, state, and private sources during fiscal year 1989, that ended June 30. This compares with \$52.2 million received in fiscal year 1988, \$42.3 million received in fiscal year 1987, and \$30.5 million received in fiscal year 1986.

The grants and contracts support a variety of programs in research, education, and student aid, as well as community health services at UMDNJ schools and health care facilities. The total does not include grants and gifts to the Foundation of UMDNJ or to University-affiliated institutes and hospitals.

Grants and contracts specifically for research totalled \$44 million, an increase of 22.4 percent over fiscal year 1988. This is significant because these funds are awarded competitively and reflect UMDNJ's ability to compete with top institutions.

By the year 2000, UMDNJ has targeted a level of \$200 million in annual revenue from grants and contracts as necessary to bring the University into the top ranks nationally. An overall increase of 20 percent in each of the next seven years is needed to achieve that level of support.

Two recent grants exemplify UMDNJ's expanding research efforts. A \$1 million federal grant for research to unravel the growth process of the AIDS virus—called replication—and then determine how to block that process, and a two-year, \$100,000 study to determine if high levels of insulin used to treat diabetes causes cardiovascular damage, funded by the Juvenile Diabetes Foundation.

Also on the research front, James R. Seibold, MD, associate professor of medicine at UMDNJ-Robert Wood Johnson Medical School, has been appointed director of UMDNJ's new \$4.5 million Clinical Research Center in New Brunswick. Dr. Seibold also has been named as the first occupant of the W.H. Conzen Chair of Clinical Pharmacology. This position, created through a \$1 million endowment to the Foundation of UMDNJ by the Schering-Plough Foundation, honors the firm's former chairman, Mr. Conzen. The endowment is the largest single donation in the history of the Schering-Plough Corporation and its Foundation.

The Clinical Research Center (CRC) is a 12-bed facility for sophisticated research programs in clinical medicine and the basic sciences. In addition to serving as a major research center for UMDNJ, the CRC will be a satellite facility for the Center For Advanced Biotechnology and Medicine, Piscataway, operated jointly by UMDNJ and Rutgers—the State University of New Jersey.

UMDNJ-New Jersey Dental School has announced two important appointments: Richard N. Buchanan, DMD, a veteran dental educator and administrator, has been named executive associate dean, a new post at the school; and James R. Hupp, DMD, MD, has been appointed chairperson of the Department of Oral and Maxillofacial Surgery. He is responsible for all clinical, educational, and research programs in the depart-

ment, focusing on such areas as dental implants, cleft palate treatment, corrective jaw surgery, and management of temporomandibular joint (TMJ) disorders. □ Stanley S. Bergen, Jr, MD

MSNJ AUXILIARY

Lobbying for sound medical legislation continues to be one of the Auxiliary's top priorities. Blitz phone operations, letter writing campaigns, and visits to legislator's offices are the key modes of operation.

In the coming months, the Auxiliary will make two legislative trips. A day at the state Capitol in Trenton is targeted for the first week in February. The agenda includes attendance at the morning Assembly proceedings and at the afternoon Senate session. Conferences with selected lawmakers also are possibilities.

The annual legislative bus trip to the nation's Capitol is scheduled for March 28 to 29, 1990. The two-day visit will start with a legislative briefing by a member of the Division of Government Affairs for the AMA Washington office. The informative session seeks to provide participants with background material on current issues, AMA policy on pending legislation, and talking points for our meetings at the Capitol with members of the Senate and House of Representatives. Incidentally, the New Jersey Auxiliary is one of the few auxiliaries in the country that makes this yearly trip to Washington, D.C. independently of its state medical society. In the past, the trip has been highly effective. This year, however, we hope to make it doubly successful by inviting our physician spouses to join us. After all, who can more forcefully discuss the issues affecting the quality of health care than physicians—the health providers, health consumers, and voting constituents?

The Auxiliary is making all the arrangements: bus transportation

to Washington and overnight accommodations at the Hyatt Regency Hotel (within walking distance of the Capitol). Mark your calendars now! Details will follow.

The county Auxiliaries have been involved in numerous other legislative activities, health projects, and fundraising for medical education. In the fall, the Aux-

iliaries focused their attention on voter registration drives. Bergen, Burlington, Camden, Gloucester, Mercer, Morris, and Union counties participated. Bergen County also inaugurated a "Legislation Alert Phone Chain," and Camden County organized a "Legislation Phone Tree." In addition, most county Auxiliaries responded to a

legislative alert from the AMA Auxiliary. Statewide phone banks were put in operation to enlist legislative support for the Senate version of the ban on smoking on all domestic flights.

County health projects included "Eye Screenings" for glaucoma conducted by the Auxiliaries and medical societies in Atlantic, Burlington, Gloucester, and Union counties. Atlantic County also held a "Sun Screening" in Atlantic City.

In Morris County, one successful health project led to another! At a Mothers' Day health program sponsored by a Morristown department store, Auxiliary members distributed breast self-examination information. It was so successful, the store invited the Auxiliary to participate in a special day planned around mastectomy prosthesis customers. Auxiliary members used the occasion to distribute "Medifile Cards" (cards to keep track of a patient's prescribed medications).

Finally, the MSNJ Auxiliary's drive is on to raise funds for AMA-ERF (American Medical Association's Education and Research Fund). Physicians will be sent raffle tickets in March and all proceeds will be used for medical education and research in New Jersey. □ Marion H. Geib

1990 MSNJ ANNUAL MEETING

Saturday, May 5, 1990

- 3:30 p.m. Board of Trustees' Meeting
- 7:00 p.m. Officers' Cocktail Reception and Dinner

Sunday, May 6, 1990

- 8:00 a.m. Registration Opens
- 8:00 a.m. Message Center Opens
- 10:00 a.m. Educational Program
- 11:00 a.m. Exhibits Open
- 1:00 p.m. House of Delegates
- 3:30 p.m. Reference Committee Meetings

Monday, May 7, 1990

- 8:00 a.m. Registration Opens
- 8:00 a.m. Message Center Opens
- 8:30 a.m. Exhibits Open
- 9:00 a.m. House of Delegates (Election)
- 12:00 noon Golden Merit Award Ceremony and Reception
- 1:00 p.m. Professional Liability Program (MIENJ)
- 2:45 p.m. Reference Committee Meetings
- 5:00 p.m. JEMPAC Political Forum
- 5:45 p.m. JEMPAC Wine and Cheese Reception
- 6:30 p.m. Somerset County Medical Society

Tuesday, May 8, 1990

- 8:00 a.m. Registration Opens
- 8:00 a.m. Message Center Opens
- 8:30 a.m. Exhibits Open
- 9:00 a.m. House of Delegates
- 1:30 p.m. House of Delegates
- 2:00 p.m. Exhibits Close
- 6:30 p.m. Inaugural Reception and Dinner

Wednesday, May 9, 1990

- 8:00 a.m. Registration Opens
- 8:00 a.m. Message Center Opens
- 8:30 a.m. General Session
- 1:00 p.m. Board of Trustees' Meeting

AMNJ REPORT

The Academy of Medicine of New Jersey is offering forums on biomedical ethics with the Citizens' Committee on Biomedical Ethics. We have been successfully cooperating with the Committee for the past two years and the new topics for the 1989 to 1990 year include: Bureaucrats at the Bedside; The Evolving Role of the Ombudsman in New Jersey; Living Wills, Brain Death: Pending Legislation and its Impact on Medical Practice; Medical Decisions and Moral Dilemmas; The Role of the Hospital Ethics Committee; and

Universal Health Care in the 1990s: Who Pays the Financial and Professional Costs? The topics currently are being offered to specialty societies, county medical societies, and hospital medical staff meetings. There is no charge for these programs and further information can be obtained by calling the Academy's Executive Offices.

The Fourth Annual Governor's Jersey Pride Awards Program will culminate on Thursday, January 4, 1990, with the presentation of 12 awards to distinguished New Jerseyans. The Governor's Awards Ceremony will take place at 8:00 P.M. at McCarter Theatre in Princeton and an entertaining and inspirational evening is planned.

The Academy's 1989 to 1990 academic year has funded roving symposia that are available to hospitals, county medical societies, and specialty societies at no charge. The Diabetes Control Program, New Jersey State Department of Health, has expanded our physician education program on the complications of diabetes to include: prevention of lower extremity amputation, retinopathy, nephropathy, and diabetes and pregnancy.

The Division of AIDS Prevention and Control of NJDOH has funded two roving symposia series. They are "Diagnoses and Treatment of AIDS," and "Counseling and Testing for AIDS." AMNJ and MSNJ will enter into the second year of the longitudinal study of physician counseling and testing knowledge, attitudes, and practice management concerning HIV+ patients.

AIDSLINE now is commencing the second year of service to the medical community acting as a central resource linking AIDS-related education programs and speakers with physicians, nurses, hospitals, community service organizations, and the New Jersey State Department of Health, Division of AIDS Prevention and Control. A monthly newsletter is

mailed to health care providers who work with the HIV+ population. AIDSLINE has responded to hundreds of physician requests for information, assistance, and referrals.

The Academy also has been awarded funding to expand its services through a joint proposal with the New Jersey Hospital Association. This will allow AMNJ to impact on additional allied health professionals within the hospital setting as well as to broaden the content and dissemination of the AIDSLINE newsletter. □ Frederick B. Cohen, MD, President

PLACEMENT FILE

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY

Hak Joo Cha, MD, 22 Hamilton Ct., Lawrenceville, NJ 08648. Catholic

Medical College 1972. Board eligible. Solo, partnership, group, fee-for-service. Available.

CARDIOLOGY

Fredric Gerewitz, MD, 125 Montgomery Ave., Bala Cynwyd, PA 19004. SUNY-Downstate 1984. Board eligible. Group or partnership. Available July 1990.

Matilda M. Taddeo, MD, 2269 Ellis Ave., Bronx, NY 10462. West Indies 1983. Board eligible. Group, partnership. Available.

GASTROENTEROLOGY

David L. Fishkin, MD, 1000J Scaife Hall, University of Pittsburgh, Pittsburgh, PA 15261. SUNY-Downstate 1985. Board eligible. Board certified (IM). Group, partnership, solo. Available July 1990.

INTERNAL MEDICINE

Albert S. Ford, MD, 943 Norway Ave., Huntington, WV 25703. Meharry Medical College 1982. Board eligible. Solo; possibly purchasing a practice. Available June 1990.

ORTHOPEDICS

D.C. Brown, MD, 2319 Sayre Dr., Princeton, NJ 08540. Available.

OTOLARYNGOLOGY

Samuel H. Selesnick, MD, 450 East 63rd St., #8F, New York, NY 10021. NYU 1985. Board eligible. Available July 1990.

224th ANNUAL MEETING MEDICAL SOCIETY OF NEW JERSEY

May 6-9, 1990

**The Sands Hotel, Casino & Country Club
Atlantic City**

**Claridge Casino Hotel
Atlantic City**

Complete the application form on page 983.
For further information, contact Eileen Pfeiffer,
Convention Manager, 609/896-1766.

CONTINUING EDUCATION

ALLERGY

January

- 4 **Asthmas and Allergies**
11 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(*St. Joseph's Hospital and Medical Center*)

ANESTHESIOLOGY

January

- 16 **Monthly Meeting**
6-9 P.M.—Ramada Inn, Clark
(*New Jersey State Society of Anesthesiologists*)

CARDIOLOGY

January

- 11 **Atherosclerosis**
11 A.M.-12 Noon—St. Joseph's Hospital and Medical Center, Paterson
(*St. Joseph's Hospital and Medical Center*)
- 12 **Nuclear Cardiology**
1-2 P.M.—North Princeton Developmental Center, Princeton
(*AMNJ*)

February

- 21 **Anti-Arrhythmic Therapy**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*AMNJ*)

DERMATOLOGY

January

- 11 **Common Dermatoses**
1:30-2:30 P.M.—Vineland Developmental Center, Vineland
(*AMNJ*)
- 17 **Robert Wood Johnson Medical School Dermatological Conferences**
6-9 P.M.—Rutgers Community Health Plan, US #1, New Brunswick
(*UMDNJ*)

February

- 21 **Robert Wood Johnson Medical School Dermatological Conferences**
6-9 P.M.—Rutgers Community

Health Plan, US #1, New Brunswick
(*UMDNJ*)

INFECTIOUS DISEASE

January

- 9 **Clinical Management of HIV Infection**
12 Noon-1 P.M.—The Hospital Center at Orange, Orange
(*AMNJ*)
- 24 **Counseling and Testing for HIV Infection**
1:30-2:30 P.M.—Trenton Psychiatric Hospital, Trenton
(*AMNJ*)

February

- 6 **Counseling and Testing for HIV Infection**
12 Noon-1 P.M.—East Orange General Hospital, East Orange
(*AMNJ*)
- 6 **Counseling and Testing for HIV Infection**
12 Noon-1 P.M.—The Hospital Center at Orange, Orange
(*AMNJ*)
- 28 **Counseling and Testing for HIV Infection**
11:30 A.M.-12:30 P.M.—Hamilton Hospital, Hamilton
(*AMNJ*)
- 28 **Clinical Management of HIV Infection**
1:30-2:30 P.M.—Trenton Psychiatric Hospital, Trenton
(*AMNJ*)

MEDICINE

January

- 3 **Medical Lecture Series**
10 10:30-11:30 A.M.—Christ Hospital, Jersey City
17 (*Christ Hospital*)
24
31
- 5 **Continuing Medical Education Series**
12 12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
19 (*South Jersey Hospital System*)
26

- 9 **Renal Biopsy Conference**
12:30-2 P.M.—Barnert Memorial Hospital Center, Paterson
(*Barnert Memorial Hospital Center*)
- 10 **Nephropathy**
12 Noon-1 P.M.—Union Hospital, Union
(*AMNJ*)
- 10 **Prevention of Lower Extremity Amputations**
9-10 A.M.—Somerset Medical Center, Somerville
(*AMNJ*)
- 12 **Food and Drug Interactions**
10:30-11:30 A.M.—Greystone Park Psychiatric Hospital, Greystone Park
(*AMNJ*)
- 16 **Host Defense Mechanisms of the Peritoneal Cavity and CAPD Peritonitis**
6:30-9:30 P.M.—Overlook Hospital, Summit
(*AMNJ*)
- 17 **Laser Treatment of Massive GI Hemorrhage and GI Carcinomas**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 17 **Common Uses in OP Treatment**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(*AMNJ*)
- 17 **Geriatric Patient and Alzheimer's Disease**
11 A.M.-12 Noon—West Hudson Hospital, Kearny
(*West Hudson Hospital*)
- 17 **Internal Medicine Review Course**
4-7 P.M.—University Hospital, New Brunswick
(*AMNJ and UMDNJ*)
- 18 **Continuing Medical Education Series**
12 Noon—Somerset Medical Center, Somerville
(*Somerset Medical Center*)
- 19 **Limb Salvage in Diabetes**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(*South Jersey Hospital System*)



Hahnemann University

Department of Medicine

WEDNESDAYS GRAND ROUNDS

8:30 A.M.-9:30 A.M.

January-May 1990

JANUARY 1990

January 3, 1990 PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY

Elliott L. Mancell, M.D.
Professor and Chairman
Department of Neurology
Hahnemann University

January 10, 1990 SODIUM SENSITIVITY & RESISTANCE OF BLOOD PRESSURE

Myron H. Weinberger, M.D.
Professor of Medicine
Director, Hypertension Research Center
Indiana University School of Medicine
Indianapolis, IN

January 17, 1990 RHEUMATOLOGY & IMMUNOLOGY NEWER ADVANCES

Rephel J. DeHoratius, M.D.
Professor of Medicine
Director, Division of Clinical Immunology and
Rheumatology
Hahnemann University

January 24, 1990 SKIN CANCER (Non-melanoma)

Gary R. Kantor, M.D.
Associate Professor of Medicine and Dermatology
Department of Medicine
Hahnemann University

January 31, 1990 SPACE MEDICINE: CARDIOVASCULAR, BONE, FLUID SHIFTS AFFECTS OF SPACE

G. John DiGregorio, M.D., Ph.D.
Professor of Pharmacology and Medicine
Director, Division of Toxicology
Consultant to N.A.S.A.
Hahnemann University

FEBRUARY 1990

February 7, 1990 SOMATOSTATIN, CARCINOID SYNDROME

John Oates, M.D.
Professor & Chairman
Department of Medicine
Vanderbilt University
Nashville, TN

February 14, 1990 LYME DISEASE

Steven Billateln, M.D., MPH
Associate Professor of Medicine
Columbia Presbyterian Medical Center
New York, NY

February 21, 1990 NEOPLASTIC DISEASE ADVANCES IN THERAPY

Isadore Brodsky, M.D.
Professor and Chairman
Department of Neoplastic Diseases
Director, Institute of Cancer & Blood Diseases
Hahnemann University

February 28, 1990 CLINICAL PATHOLOGIC CONFERENCE

Chief Residents:
Michael DeAngelis, M.D.
Ana Nunaz, M.D.
Ralph McKibban, M.D.
Matthew Sandler, M.D.

MARCH 1990

March 7, 1990 IMMUNE INTERVENTION IN TYPE I DIABETES MELLITUS

Jey S. Skyler, M.D.
Professor of Medicine
Director, Diabetes Mellitus
University of Miami
Miami, FL

March 14, 1990 COPD: PATHOGENESIS AND TREATMENT ADVANCES

Mark J. Utell, M.D.
Professor of Medicine and Toxicology
University of Rochester
Rochester, NY

March 21, 1990 CLINICAL PHARMACOLOGY

Vincent J. Zarro, M.D., Ph.D.
Associate Professor of Pharmacology & Medicine
Director, Division of Clinical Pharmacology
Hahnemann University

March 28, 1990 DERMATOLOGIC TREATMENT WITH RETINOIDS AND CYCLOSPORINE

Richard L. Spalvogel, M.D.
Professor of Medicine and Dermatology
Director, Division of Dermatology
Hahnemann University

APRIL 1990

April 4, 1990 CARDIAC ELECTROPHYSIOLOGY: EVOLVING DIAGNOSTIC AND THERAPEUTIC MODALITIES

John D. Fisher, M.D.
Professor of Medicine
Director, Cardiac Arrhythmia Service
Acting Director, Division of Cardiology
Montefiore Medical Center
New York, NY

April 11, 1990 MEDICAL MANAGEMENT OF GALLSTONE DISEASE

Hana Fromm, M.D.
Professor of Medicine
Director, Division of Gastroenterology
The George Washington University
Washington, DC

April 18, 1990 ENDOCRINOLOGY AND METABOLISM: RECENT ADVANCES

Leslie I. Rose, M.D.
Professor of Medicine
Director, Division of Endocrinology and
Metabolism
Hahnemann University

Jeffrey L. Miller, M.D.
Associate Professor of Medicine
Division of Endocrinology and Metabolism
Hahnemann University

April 25, 1990
TREATMENT OF DIFFICULT GRAM
NEGATIVE BACTERIAL INFECTIONS
William E. Dismukes, M.D.
Professor & Vice Chairman for Educational
Programs
Department of Medicine
University of Alabama
Birmingham, AL

MAY 1990

MAY 2, 1990 VENOUS THROMBOEMBOLIC DISORDERS: UPDATE 1990

John C. Hoek, M.D.
Director, Division of Blood Diseases and
Resources
National Heart, Lung and Blood Institute
National Institutes of Health
Bethesda, MD

May 9, 1990 IMMUNE MECHANISMS: BREAKTHROUGHS IN IMMUNOSUPPRESSION

George H. Hitchings, Jr., Ph.D., D.Sc.
Noble Prize Winner 1988 in Medicine and
Physiology
Duke University
Durham, NC
Adjunct Professor of Pharmacology
University of North Carolina
Chapel Hill, NC
Scientist Emeritus
Burroughs Wellcome Co.

Terry Strom, M.D.
Professor of Medicine
Harvard Medical School
Director of Clinical Immunology
Beth Israel Hospital
Boston, MA

May 16, 1990 INFECTIOUS DISEASES: NEWEST ADVANCES

Abdolghader Molavi, M.D.
Associate Professor of Medicine & Surgery
Director, Division of Infectious Diseases
Hahnemann University

May 23, 1990 "NEW FASHION" CLINICAL PATHOLOGIC CONFERENCE

Kenneth Cohen, M.D.
Assistant Professor of Medicine
Director, Internal Medicine Residency Program
Hahnemann University

May 30, 1990 "OLD FASHION" CLINICAL PATHOLOGIC CONFERENCE

Eugene Coodley, M.D.
Professor of Medicine
University of California, Irvine
Director of Geriatric Medicine
Long Beach VA Hospital
Long Beach, CA

1990—WEDNESDAY—1990

MEDICAL SEMINAR SERIES

8:30 A.M.-3:00 P.M.

January 10, 1990

HYPERTENSION: Mechanisms and Treatment

March 7, 1990

DIABETES MELLITUS: Immune Mechanisms & Insulin Therapy Innovations

March 28, 1990

DERMATOLOGY: Treatment with Retinoids and Cyclosporine

April 25, 1990

DIFFICULT GRAM NEGATIVE AND FUNGAL INFECTIONS

May 9, 1990

IMMUNOTHERAPY AND KIDNEY TRANSPLANTATION

Presented by:

William S. Frankl, M.D.
Professor of Medicine and Chairman
Department of Medicine
Allan B. Schwartz, M.D.
Professor of Medicine
Director, Continuing Medical Education
Department of Medicine

Classroom C (Alumni Hall)
2nd Floor New College Bldg.
Hahnemann University
15th Street Entrance
15th and Vine Streets
Philadelphia, PA

We wish to acknowledge educational grant support from:

E.R. Squibb & Sons
Merck, Sherpe & Dohme
Burroughs Wellcome & Co.
Squibb-Nowo
Sandoz
Roche
CIBA-Gaigy

Approved for CME credits through the Office of Continuing Education, Hahnemann University

- 20 Morbidity and Mortality Conference**
8:30-10 A.M.—New Jersey Medical School, Newark
(*UMDNJ*)
- 23 Lyme Disease**
1:30-2:30 P.M.—Hunterdon Developmental Center, Clinton
(*AMNJ*)
- 23 Dually Diagnosed**
2:30-3:30 P.M.—New Lisbon Developmental Center, New Lisbon
(*AMNJ*)
- 24 Diabetes in Pregnancy**
9-10 A.M.—Somerset Medical Center, Somerville
(*AMNJ*)
- 24 Diabetic Retinopathy**
12 Noon-1 P.M.—St. James Hospital, Newark
(*AMNJ*)
- 25 Visiting Professor Program**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(*Saint Barnabas Medical Center*)
- 26 Update in Ophthalmology**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(*South Jersey Hospital System*)
- 26 Neurological Assessment**
10:30-11:30 A.M.—Greystone Park Psychiatric Hospital, Greystone Park
(*AMNJ*)
- February**
- 1 Adrenal Disease**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(*AMNJ*)
- 2 Update on Antibiotic Therapy**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(*South Jersey Hospital System*)
- 2 Continuing Medical Education Program**
- 16** 12 Noon-1 P.M.—United Hospitals
- 23** Medical Center, Newark
(*United Hospitals Medical Center*)
- 7 Winter Dinner Meeting**
6:30 P.M.—The Hilton at Short Hills, Short Hills
(*New Jersey Gastroenterological Society*)
- 7 Medical Lecture Series**
- 14** 10:30-11:30 A.M.—Christ
- 21** Hospital, Jersey City
- 28** (*Christ Hospital*)
- 7 Internal Medicine Review Course**
- 14** 4-7 P.M.—University Hospital,
- 28** New Brunswick
(*AMNJ and UMDNJ*)
- 7 Urinary Incontinence of the**

- Elderly**
2-3 P.M.—John E. Runnells Hospital of Union County, Berkeley Heights
(*AMNJ*)
- 9 How Healthcare Professionals Can Protect Themselves from Frivolous Lawsuits**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(*South Jersey Hospital System*)
- 12 Fluid and Electrolyte Imbalance**
7-8 P.M.—Wallkill Valley General Hospital, Sussex
(*AMNJ*)
- 15 Continuing Medical Education**
12 Noon—Somerset Medical Center, Somerville
(*Somerset Medical Center*)
- 16 Role of NSAIDS in the Geriatric Population**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(*South Jersey Hospital System*)
- 17 Morbidity and Mortality Conference**
8:30-10 A.M.—New Jersey Medical School, Newark
(*UMDNJ*)
- 21 Dually Diagnosed**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(*AMNJ*)
- 22 Visiting Professor Program**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(*Saint Barnabas Medical Center*)
- 24 Diabetic Nephropathy**

12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(*AMNJ*)

OBSTETRICS AND GYNECOLOGY

January

- 12- Third Annual Practical**
- 14 Approaches to the Ob-Gyn Specialties**
7 A.M.-1 P.M. daily—Condado Plaza Hotel, San Juan, Puerto Rico
(*UMDNJ*)

February

- 14 Prematurity, Postmaturity, and Dysmaturity**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 14 Diabetes in Pregnancy**
12 Noon-1 P.M.—St. James Hospital, Newark
(*AMNJ*)

ONCOLOGY

January

- 10 Tumor Board Conference**
12 Noon-1 P.M.—Memorial Hospital of Salem County, Salem
(*Memorial Hospital of Salem County*)
- 12 Tumor Board Meeting**
11 A.M.-12 Noon—Wallkill Valley Hospital Center, Sussex
(*Wallkill Valley Hospital Center*)
- 25 Tumor Board Conference**
12 Noon-1 P.M.—Newcomb Medical Center, Vineland
(*Newcomb Medical Center*)

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____

PHILADELPHIA HEART INSTITUTE
of Presbyterian Medical Center

Cardiology Update

*designed for the physician and provides an intensive
survey of the current status of clinical cardiology. . .*

Wednesday, January 3, 1990 3:00-5:00 PM

Conventional and Investigational Antiarrhythmic Drugs

Moderator

Leonard N. Horowitz, M.D.

3:00-3:30	Treatment of premature ventricular complexes in the 1990's	<i>Francis E. Marchlinski, M.D.</i>
3:30-4:00	What the doctor should know about old and new antiarrhythmic drugs	<i>Leonard N. Horowitz, M.D.</i>
4:00-5:00	Case presentations—Simple and complex cardiac arrhythmias	<i>Sally G. Beer, M.D.</i>
	Panel discussion	
	<i>Michael S. Feldman, M.D.</i>	
	<i>Charles Gottlieb, M.D.</i>	
	<i>Jan R. Weber, M.D.</i>	

- Case Presentations and Panel Discussions
- CME Credits*
- No Registration Fee
- Call for Reservation 215-662-8627

Scheie Auditorium
Presbyterian Medical Center
39th & Market Streets
Philadelphia, Pennsylvania 19104

*The Philadelphia Heart Institute at Presbyterian Medical Center is an affiliate of the University of Pennsylvania. "The University of Pennsylvania School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The University of Pennsylvania School of Medicine designates this Continuing Medical Education activity for 2 credit hours per session in Category 1 of the Physician's Recognition Award of the American Medical Association."

February

- 9 Tumor Board Meeting**
11 A.M.-12 Noon—Wallkill Valley Hospital Center, Sussex
(*Wallkill Valley Hospital Center*)
- 14 Tumor Board Conference**
12 Noon-1 P.M.—Memorial Hospital of Salem County, Salem
(*Memorial Hospital of Salem County*)
- 22 Tumor Board Conference**
12 Noon-1 P.M.—Newcomb Medical Center, Vineland
(*Newcomb Medical Center*)
- 25 11th Annual Tumor Board Conference**
6-9 P.M.—MSNJ Headquarters, Lawrenceville
(*Oncology Society*)

PEDIATRICS

January

- 3 Child Abuse—Neglect**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 4 Pediatric Grand Rounds**
11 8:30-9:30 A.M.—Robert Wood Johnson Medical School, MEB,
18 102, New Brunswick
(*UMDNJ*)
- 18 Update in Aspects of Pediatrics**
Marriott Hotel, Saddle Brook
(*Northern NJ Pediatric Society*)

February

- 1 Pediatric Grand Rounds**
8 8:30-9:30 A.M.—Robert Wood Johnson Medical School, MEB,
15 102, New Brunswick
(*UMDNJ*)
- 22 Update in Aspects of Pediatrics**
Marriott Hotel, Saddle Brook
(*Northern NJ Pediatric Society*)
- 27 Update in Ribavirin Therapy**
12 Noon-1 P.M.—Newark Beth Israel Medical Center, Newark
(*Newark Beth Israel Medical Center*)

PSYCHIATRY

January

- 4 Case Seminars To Improve**
18 Psychotherapeutic Technique
8-10 P.M.—2 West Northfield Road, Livingston
(*Advanced Psychiatric Study Group*)
- 5 Addictions**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(*South Jersey Hospital System*)
- 10 Adult Suicide**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*AMNJ*)

11 Teenage Suicide

1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(*AMNJ*)

February

- 1 Case Seminars To Improve**
15 Psychotherapeutic Technique
8-10 P.M.—2 West Northfield Road, Livingston
(*Advanced Psychiatric Study Group*)
- 6 Anxiety Disorders**
10-11 A.M.—Green Brook Regional Center, Green Brook
(*AMNJ*)
- 7 Medical Aspects of Behavior Management**
10-11 A.M.—Johnstone Training and Research Center, Bordentown
(*AMNJ*)

RADIOLOGY

January

- 11 Scientific Meeting**
7:30-9:30 P.M.—Overlook Hospital, Summit
(*New Jersey Institute for Ultrasound in Medicine*)
- 18 1990 Scientific Meeting**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(*Radiological Society of New Jersey-Diagnostic Section, AMNJ*)
- 25 Visiting Professor Program**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(*Saint Barnabas Medical Center*)

February

- 7 Ultrasound**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(*St. Mary's Hospital*)
- 15 1989 Scientific Meeting**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(*Radiological Society of New Jersey-Diagnostic Section, AMNJ*)
- 22 Visiting Professor Program**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(*Saint Barnabas Medical Center*)

SURGERY AND ITS SPECIALTIES

January

- 2 Weekly Vascular Case**
9 Conference
16 7:30-8:30 A.M.—Robert Wood Johnson Medical School, MEB,
23 108B, New Brunswick
(*UMDNJ*)
- 30 Surgical Treatment of Cardiothoracic Disease**

10-11:30 A.M.—New Jersey Medical School, MSB, 506B, Newark
(*UMDNJ*)

- 20 Morbidity and Mortality**
27 Conference
8:30-10 A.M.—New Jersey Medical School, MSB, 506B, Newark
(*UMDNJ*)
- 23 Englewood Surgical Society Lecture Series**
8-10 P.M.—The Englewood Club, Englewood
(*Englewood Surgical Society*)
- 31 Journal Club, Section of Cardiothoracic Surgery**
6:30-9:30 P.M.—2 Mountain Ridge Drive, Livingston
(*UMDNJ*)

February

- 4 Surgical Treatment of Cardiothoracic Disease**
10-11:30 A.M.—New Jersey Medical School, MSB, 506B, Newark
(*UMDNJ*)
- 6 Weekly Vascular Case**
13 Conference
20 7:30-8:30 A.M.—Robert Wood Johnson Medical School, MEB,
27 108B, New Brunswick
(*UMDNJ*)
- 17 Morbidity and Mortality**
24 Conference
8:30-10 A.M.—New Jersey Medical School, MSB, 506B, Newark
(*UMDNJ*)
- 27 Englewood Surgical Society Lecture Series**
8-10 P.M.—Englewood Club
(*Englewood Surgical Society*)
- 28 Journal Club, Section of Cardiothoracic Surgery**
6:30-9:30 P.M.—2 Mountain Ridge Drive, Livingston
(*UMDNJ*)

UROLOGY

January

- 5 Urology Grand Rounds**
12 New Jersey Medical School,
19 MSB, C600, Newark
26 (*UMDNJ*)
- 24 Winter Meeting**
6:30 P.M.—Holiday Inn, Jamesburg
(*Urology Society of New Jersey*)

February

- 2 Urology Grand Rounds**
9 New Jersey Medical School,
16 MSB, C600, Newark
23 (*UMDNJ*)

The Academy of Medicine
of New Jersey
in cooperation with

UMDNJ—Robert Wood Johnson Medical School
& Robert Wood Johnson University Hospital

present

AN INTENSIVE REVIEW OF INTERNAL MEDICINE

January 17, 1990-May 23, 1990
Wednesdays

4:00 P.M.-7:00 P.M.

at

ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL
NEW BRUNSWICK, NEW JERSEY

The course is designed to provide a comprehensive review of contemporary concepts in Internal Medicine. It is designed for practicing internists and family practitioners. The review will also be useful for residents. Syllabus material will be distributed during the course which will, when compiled, provide an extremely useful reference.

COURSE CHAIR: Robert Eisinger, M.D.

*For further information on registration, faculty
and fees, please contact:*



Diane Delfino
Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, New Jersey 08648
609-896-1717



INC.

Doctors Disposal Service, Inc.

2110 Maple Avenue
South Plainfield, NJ 07080

Licensed by:

STATE OF NEW JERSEY

Department of Environmental Protection

Professional removal of sharps and special medical
waste . . . Disposal by incineration . . . Reliable, worry
free service . . . Reasonable rates . . .

For information in New Jersey call toll free

1-800-447-0026

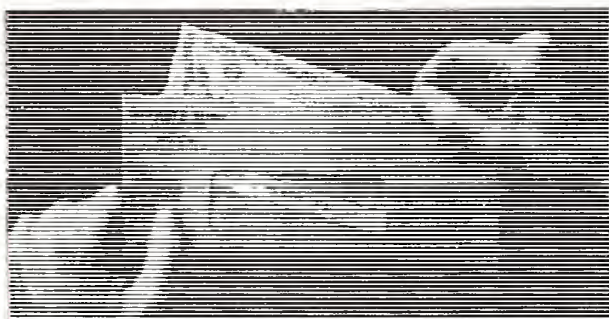
NEW JERSEY MEDICINE

OPPORTUNITIES

CME

Pages 989-994

WE'LL HELP YOU PAY OFF \$20,000 OF YOUR MEDICAL SCHOOL LOANS.



If you're certified in one of the following specialties:

■ anesthesiology ■ general surgery ■ thoracic surgery ■ orthopedic surgery ■ neurosurgery ■ emergency medicine

you could take part in the Army Reserve's Health Professionals' Loan Repayment Program that pays as much as \$20,000 in medical school loans.

As a member of the Army Reserve, you could be serving your country near home at times convenient to you. You'll also enjoy all the prestige and privileges that accompany being an officer.

To find out more about the Health Professionals' Loan Repayment Program and all the other advantages of the Army Reserve, contact one of our experienced Army Reserve Medical Counselors. They can arrange for you to talk to an Army Reserve physician and visit a Reserve Center or medical facility.

Call collect:

Major Mary P. Sherman
609-667-8190

Collect

BE ALL YOU CAN BE.®

ARMY RESERVE

IN MEMORIAM

Joseph J. Balsamo. Retired surgeon, Joseph John Balsamo, MD, died at the age of 82, on September 19, 1989. Born in Newark, Dr. Balsamo received his medical degree from the University of Bologna Medical School, Italy, in 1937. During his lengthy career, he was affiliated with Columbus Hospital, Newark. Dr. Balsamo was a member of our Essex County component and of the AMA. In 1987, Dr. Balsamo received MSNJ's Golden Merit Award.

Arlington Bensel. Word has been received of the death in August 1989 of Arlington Bensel, MD, a member of our Monmouth County component. Born in 1915, Dr. Bensel earned his medical degree at Temple University School of Medicine, Pennsylvania, in 1942, and was awarded his New Jersey license in 1943. A dermatologist, Dr. Bensel was affiliated with East Orange General Hospital; Saint Barnabas Medical Center, Livingston; and Monmouth Medical Center, Long Branch. A fellow of the Academy of Medicine of New Jersey, Dr. Bensel was a diplomate of the American Board of Dermatology.

Lenn Jay Chalfin. After a long illness, Lenn Jay Chalfin, MD, died at the untimely age of 38. Born in 1951 in Philadelphia, Dr. Chalfin received his medical degree from Jefferson Medical College in 1976. He completed his residency at Albert Einstein Medical Center, Pennsylvania, and at Thomas Jefferson University Hospital. From 1981 to 1983, he served a fellowship at the University of

Florida at Gainesville. During his short career as a specialist in plastic and reconstructive surgery, Dr. Chalfin was affiliated with Burdette Tomlin Medical Center, Cape May Court House. He was a member of our Cape May County component and a diplomate of the American Board of Surgery.

John P. Coughlin. A retired member of our Hudson County component, John P. Coughlin, MD, died on September 2, 1989. Born in 1905, Dr. Coughlin received his medical degree from Georgetown University School of Medicine, Washington, in 1932. A surgeon, Dr. Coughlin served as president of St. Francis Hospital, Jersey City, in the 1960s. He also was affiliated with Margaret Hague Hospital, Jersey City. Dr. Coughlin was a member of the AMA and a fellow of the American College of Surgeons.

Raymond S. Driscoll. After over 50 years of general practice in Bayonne, Raymond Sylvester Driscoll, MD, died on July 20, 1989. A 1906 Bayonne native, and a longtime area resident, Dr. Driscoll received his medical degree from Georgetown University School of Medicine, Washington, DC, in 1930, and his New Jersey license in 1931. In addition to running a private general and surgical practice, Dr. Driscoll was associate attending at Bayonne Hospital, and actively served his community as medical director for the Hudson County Parental School; and as surgeon for the U.S. Department of Labor in Bayonne. He received the Medical Society of

New Jersey's Golden Merit Award in 1989 for his 50 years as a physician. During World War II, Dr. Driscoll was a major in the United States Army medical corps. He was a member of our Hudson County component and of the American Medical Association.

Abraham S. Effron. Paterson neurology and psychiatry specialist Abraham Samuel Effron, MD, died on September 12, 1989, at the age of 71. Born in New York City, Dr. Effron was awarded his medical degree from Queen's University, Belfast, Ireland, in 1942. A longtime resident of Paterson, Dr. Effron has been in practice there since 1950, serving also as a consulting physician at Barnert Memorial Hospital Center, Paterson; and at Chilton Memorial Hospital, Pompton Plains. A member of our Passaic County component, Dr. Effron was a diplomate in neurology, and a fellow of the American Geriatric Society and of the American Psychiatric Association.

A. Bradford Judd. At the age of 60, Alvan Bradford Judd, MD, a member of our Monmouth County component, died on September 9, 1989. Born in 1929 in Detroit, Dr. Judd received his medical degree from Harvard University School of Medicine, Massachusetts, in 1954. He served his internship at Massachusetts Mental Health Center, Boston. He relocated to Shrewsbury and had a private practice, specializing in child and adult psychology. From 1960 to 1964, he was director of training and from 1964 to 1967, he was medical director of the Children's Psychiatric Center,

Eatontown. In addition, he served on the board of the Arthur Brisbane Child Treatment Center, Wall Township, from 1967 to 1970. At the time of his death, he was a researcher at the Space Medicine Institute for Advanced Studies at Princeton University. Dr. Judd was a diplomate of the American Board of Psychiatry, a member of the American Medical Association, and a fellow of the American Academy of Child Psychology.

Milton Lane. A member of our Union County component, Milton Lane, MD, died on July 12, 1989. Born in 1911 in Brooklyn, New York, Dr. Lane received his medical degree from Ohio State Medical School in 1937. He served in the United States Army from 1938 to 1946, as a lieutenant colonel. Dr. Lane was awarded his New Jersey license in 1946 and during his lengthy career as a family practitioner, he was affiliated with Overlook Hospital, Summit; General Hospital, Irvington; and Newark Beth Israel Medical Center. Dr. Lane also was a member of the American Medical Association.

Albert G. Markel. Passaic County component member Albert Gross Markel, MD, died on August 30, 1989. Born in New York City in 1902, Dr. Markel was awarded his medical degree in 1925 from Syracuse University School of Medicine, New York. Dr. Markel practiced in Paterson for almost 50 years; during his career he was affiliated with Wayne General Hospital and Paterson General Hospital. Dr. Markel was a fellow of the American College of Physicians and of the American College of Cardiology; he was a diplomate of the American Board of Internal Medicine, and a member of the American Medical Association.

Cyrus G. Nucci. Orthopedic surgeon Cyrus Giulio Nucci, MD, of Bedminster, died on July 8, 1989, at the age of 63. A member

of our Essex County component, Dr. Nucci was affiliated with Columbus Hospital, St. James Hospital, and University Hospital, all in Newark, and with Clara Maass Medical Center, Belleville. Born in 1925, Dr. Nucci earned his medical degree from the Bologna Medical School, Italy, in 1957. He served an internship at Saint Michael's Medical Center, Newark, and received his New Jersey license in 1959. Dr. Nucci was a diplomate of the American Board of Orthopedics and a member of the NJ Orthopedic Society.

John C. Patterson. A Freehold psychiatrist, John C. Patterson, MD, died in September 1989, at the age of 70. A 1942 graduate of Jefferson Medical College, Philadelphia, he was superintendent of Augusta State Hospital, Maine, from 1962 to 1971. He was a private practitioner in Freehold from 1971 until 1988, and was affiliated with Monmouth Medical Center, Long Branch. A diplomate of the American Board of Psychiatry, Dr. Patterson was a fellow of the American Psychiatric Association (serving as its president in 1983), and a member of the American Medical Association and of the Freehold Rotary Club. Dr. Patterson served as a major in the Army medical corps from 1943 to 1946.

Seymour H. Shore. Aberdeen family physician Seymour Harry Shore, MD, died on September 4, 1989, at the age of 61. Born in Brooklyn, New York, and a resident until moving to Aberdeen 26 years ago, Dr. Shore received his medical degree from New York Medical College in 1962. In addition to his private practice in Aberdeen, Dr. Shore was affiliated with Bayshore Community Hospital, Holmdel, where he served as vice-president and president. He also was on the faculty of UMDNJ-Rutgers University. Dr. Shore was a diplomate in family practice and was a fellow of the American

Academy of Family Practice. He was a member of our Monmouth County component and of the AMA. Dr. Shore was a U.S. Army veteran of World War II.

Milton M. Willner. A retired member of our Essex County component, Milton Michael Willner, MD, died on September 12, 1989. Dr. Willner was the retired director of the Department of Medical Research of Hoffmann-La Roche Inc. and also had a pediatrics practice in northern New Jersey. Born in 1916, Dr. Willner earned his medical degree from Cornell University and the New York Medical College, New York, in 1941. A diplomate of the American Board of Pediatrics and a fellow of the American Academy of Pediatrics and of the Academy of Medicine of New Jersey, Dr. Willner was affiliated with Newark Beth Israel Medical Center and Children's Hospital, both in Newark. In addition, he was a clinical instructor at UMDNJ and New York Medical College. From 1943 to 1946, Dr. Willner served in the Army Air Force as a captain.

Coler Zimmerman. Internal medicine and chest specialist Coler Zimmerman, MD, of West Orange, died on September 15, 1989, at the age of 82. A native of Newark, Dr. Zimmerman lived in South Orange and East Orange before moving to West Orange 20 years ago. A graduate of Jefferson Medical College, Philadelphia, Pennsylvania, Dr. Zimmerman maintained a private practice in East Orange from 1932 until his retirement in 1977. He was a staff member at East Orange General Hospital and at The Hospital Center at Orange, as well. A fellow of the American College of Chest Physicians, Dr. Zimmerman was a member of our Essex County component and of the AMA. In 1981, he was a recipient of the Golden Merit Award. Dr. Zimmerman was a captain in the U.S. Army during World War II.



NOT TO CIRCULATE

NOT TO CIRCULATE



